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Programs

Degree: Master of Education

Year This Degree Granted: 2001

University of Alberta

A Descriptive Survey of Adolescent School-Based Suicide Prevention Programs

by

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A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfilment

of the requirements for the degree of Master of Education

in

Counselling Psychology

Department of Educational Psychology

Edmonton, Alberta

Fall 2001

University of Alberta

Faculty of Graduate Studies and Research

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled A Descriptive Survey of Adolescent School-Based Suicide Prevention Programs submitted by Andrea Forgeron in partial fulfilment of the requirements for the degree of Master of Education in Counselling Psychology.

Abstract

This study describes school-based adolescent suicide prevention programs within three Edmonton and area school districts (Elk Island Public Schools, Edmonton Catholic Schools, and St. Albert Protestant Schools), and provides an analysis of the views of school counsellors regarding suicide prevention and their state of preparedness for dealing with the issue. Data were obtained from 23 school counsellors and 15 Graduate student school counsellors. The survey was based on questions developed by Malley, Kush, and Bogo (1994). Results were compared to the literature recommended components of a Comprehensive School-Based Suicide Prevention program. Results revealed that schools are addressing the problem of adolescent suicide, but there is considerable variation in the content and structure of these efforts. In addition, more than half of the school counsellors reported feeling prepared to deal with suicide and factors contributing to this feeling are identified. Implications for practice in the schools are discussed.

Acknowledgments

I would like to express sincere thanks to Dr. Robin Everall, thesis supervisor, for her time, assistance, encouragement , and clarity of thought during the course of this project. My appreciation is also extended to the other committee members, Dr. Barbara Paulson and Dr. Jill McClay, for their participation and suggestions.

I would to like acknowledge the love, support, prayers, and encouragement I received from my family throughout this long process. Special thanks go to my parents, Linda and Steve, and my brother, Darren.

Special thanks go to my partner and best friend, Jason, for his love, support, and encouragement throughout this long process.

I would like to extend thanks to my colleague Mona for her friendship and kindness throughout the past two years.

Finally, I would also like to thank the staff at the Suicide Information and Education Center for their helpful assistance and valuable data.

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CHAPTER 1

INTRODUCTION

Statement of the Problem

Suicide now ranks among the major causes of death in Canada, and its incidence has dramatically increased in recent decades (SIEC, 1999). During the 1950's to 1980's, the rate of increase was particularly evident among young adults and adolescents (Health Canada, 1995). Youth suicide is particularly distressing because adolescence is generally considered to be a carefree time, characterized by great expectations and hope for the future (White, 1995). It is therefore unsettling when some young people become so distraught that they wilfully take their own lives. Upon hearing of such acts, we often ask ourselves: "What has led this young person to feel so hopeless and alone?", "Is there anything we can do to deal with this issue?", "What steps are currently being taken to address the problem?", and most importantly, "What can society do to prevent such tragedies?"

Many school districts throughout North America have taken up the challenge posed by these important questions. This effort has led to the development of a number of school-based suicide prevention programs (Barrett-Hicks, 1990; Calgary Board of Education, cited in Dickson, 1991; Kalafat, 1991; Kirk, 1993; Raymond, 1991, cited in Wenckstern, Leenaars, & Tierney, 1995). Many of these programs provide guidelines to help schools deal with suicide. There is however, no accepted unified approach describing how this should be done, nor is there one intervention approach that has proven to be more effective than others. The topic of suicide is also charged with much debate and emotion (Hazell & King, 1996; Miller & DuPaul, 1996; Overholser,

Hemstreet, Spirito, & Vyse, 1989). For instance, there is even disagreement about whether suicide awareness programs should be implemented in schools at all. Some people fear that such programs might actually increase the frequency of suicide. However, advocates of awareness programs claim they are useful for educating students about suicidal behaviour, and may therefore help to prevent it. Schools are viewed as ideal locations for the implementation of suicide prevention programs, because schools are found in almost every community, and school staff are in daily contact with large populations of adolescents (Tierney, Ramsay, Tanney, & Lang, 1990).

School-based suicide prevention programs may involve activities that educate, identify, and intervene with potentially at-risk youth (Kush, 1991). Based on a literature search, it appears that the most frequently recommended type of program is the Comprehensive Suicide Prevention Program. This program is based on Gerald Caplan's (1964, cited in Leenaars & Wenckstern, 1999) approach to the prevention of mental health problems. Caplan distinguished among primary, secondary, and tertiary prevention. When applied to suicide, these concepts are commonly referred to as prevention, intervention, and postvention (Leenaars & Wenckstern, 1999). Comprehensive school-based suicide prevention programs contain elements which attempt to prevent suicides from taking place, deal with the situation when a suicidal crisis develops, and provide some form of follow-up after a suicide has actually occurred (Kush, 1991).

Malley, Kush, and Bogo (1994) conducted a complete literature review of the most commonly referred to components of a comprehensive suicide prevention program. They identified 16 criteria that fall under 6 broad headings (to be discussed later in

Chapter 2). Using these criteria, a survey of schools in the United States was conducted to determine how the adolescent suicide problem was being addressed. They found that nearly one-half of the schools in their study did not have a formal suicide prevention program, and in general the school-based suicide prevention efforts were not comprehensive in nature.

Many suggestions have been made regarding the constitution of an effective suicide prevention program, but there is limited information describing what is actually being done in the schools. Malley et al. (1994) have stated that more information on the specific content of school-based programs is needed. According to a post-1985 literature review of the Suicide Information and Education Center database, Tierney, Ramsay, Tanney, & Lang (1990) reported that it was difficult to ascertain the nature of suicide prevention programs because public domain publications were limited in number. This study will hopefully help to expand the knowledge in this area.

In most schools, the school counsellor is usually responsible for dealing with mental health issues (including suicide). By virtue of their position, they can play a pivotal role in the implementation of school-based suicide prevention initiatives. They are also in a unique position to provide classroom peer suicide prevention education, to assess and intervene with students in crisis, provide supportive counselling to at-risk youth, and collaborate with other school and community professionals in program construction and crisis management (Kush, 1991). Each of these specific functions requires a certain minimum level of knowledge and training in the skills of adolescent suicide prevention. However, an American-based study found that 62% of school counsellors felt unprepared to curb suicides (King, cited in Meyer, 2000). In addition, Kush (1991)

reported that 51% of the counsellors felt they had received inadequate training to deal effectively with the issue of suicide. Considering the magnitude and seriousness of the suicide problem, this percentage appears to be alarmingly high.

Purpose of the Study

This thesis examines suicide prevention programs that are currently in place in three school districts in and around Edmonton, Alberta. It extends the Malley, Kush, and Bogo (1994) study to the Canadian scene, and uses the same survey questions that were employed in that American study. This project was designed to examine three specific areas in the matter of school-based adolescent suicide prevention programming: 1) the components of existing school-based programs and practices, 2) the topics included in classroom discussions, and 3) the professional views of counsellors regarding suicide prevention, and their level of preparedness to deal with the issue. The obtained data were organized and compared to the literature-based recommended components of a comprehensive school-based suicide prevention program. This study was then used to estimate the "state of reality" regarding suicide prevention programs in the selected Edmonton and area schools.

Significance to Schools

Literature research has outlined three essential areas of suicide prevention: prevention, intervention, and postvention. In the public domain, however, information describing what is *actually* being done in the schools is very limited. The current study addresses this issue, and describes what is currently being done in the schools in the greater Edmonton area. In addition, given the seriousness of the adolescent suicide problem, it is important that schools be prepared to deal with it effectively. Once the

information generated by this study is analysed, its results can be made available to the school districts that provided it. In this way, the schools will be able to see how their program compares to others, and whether or not it meets the minimum requirements of a comprehensive program. Armed with this information, counsellors may be able to help revise or modify their own programs and bring them in line with current research.

Two American-based studies found that 62% and 51% of school counsellors did not believe they were prepared to curb suicide. This is a very high percentage considering the magnitude of the suicide problem, and the trauma it causes in individual families, educational institutions, and communities. This study should provide a good indication of how the Edmonton and American rates compare. It could also prove to be truly informative if the reasons why counsellors feel unprepared can be determined, and some ways and means of rectifying the situation could be devised.

Finally, through its request for counsellor perspectives on suicide prevention, this survey may also provide some practical information which could be adopted to improve programs. It may also serve as a useful guide for schools and school districts that do not currently have a comprehensive program in place, but are interested in implementing one.

Problem Statement

The purpose of this project is to describe existing school-based suicide prevention programs and practices, and provide an analysis of the views of school counsellors regarding suicide prevention and their state of preparedness for dealing with the issue.

Research Questions

1. Using the school counsellor reports as a basis, how many schools in this survey currently have a formal written suicide prevention policy/program in place? Does the policy contain the literature-recommended elements?

2. How do the descriptions of the components of the adolescent suicide prevention programs in the surveyed schools compare to the literature recommendations for a comprehensive school-based adolescent suicide prevention program?

3. If, or when the subject of suicide is addressed during class, what areas are covered?

4. On the basis of their self reports, do school counsellors feel prepared to curb suicides in their schools? If so, what contributes to this feeling of being prepared? If they do not feel prepared, what elements do they think are missing?

5. Based upon the content of counsellor self reports, what could be changed or added to improve the way suicide is dealt with in their own school?

6. Based upon counsellor self reports what is/are the goals of the current suicide prevention program?

Definition of Terms

For the purposes of this study, the definitions utilized by Kush (1991) will be employed.

At-Risk student - A middle or secondary school student who exhibits any manifestation or combination of risk factors that are indicative of suicidal behaviour.

Components of a School-Based Adolescent Suicide Prevention Program - The subdivisions of a school-based adolescent suicide prevention program that focus on specific areas or functions within the program (i.e., staff training, crisis intervention procedures, postvention programming, etc.)

Comprehensive School-Based Adolescent Suicide Prevention Program - A school-based adolescent suicide prevention program which is broad in its scope and contains the recommended programmatic components in areas of program construction, program implementation, prevention, intervention, postvention, and evaluation.

Feeling prepared to deal with the issue of suicide - School counsellor perceptions of their ability to perform suicide prevention and intervention at their respective schools, at a competent or mastery level.

Formal School-Based Suicide Program/Policy - A document that has been incorporated in a school through school board approval, and which serves as a directive regarding school-based programming and/or student services in the area of suicide prevention/intervention.

School-based suicide prevention programming - Any combination of formally instituted components operational at a school directed specifically toward the prevention of adolescent suicide.

Suicide Intervention - The treatment and care of a suicidal crisis or suicidal problems (Kush, 1991). This includes the early recognition and assessment of risk, immediate response, resource referrals, and follow-up management and treatment of individuals at-risk of suicide (Health and Welfare Canada, 1995).

Suicide Prevention - Methods or means which try to keep suicidal behaviour from occurring (Davis, 1983).

Suicide Postvention - the general care and support, or special treatment needed by survivors of a suicide (Health and Welfare Canada, 1995).

<u>Suicide attempt</u> - Those situations in which a person has performed an actual or seeming life-threatening behaviour with the intent of jeopardizing his/her life, or to give the appearance of such intent, but has not resulted in death (Pokorny, 1974, cited in Kush).

<u>Suicide</u> - an intentional act of self-injury resulting in death (Mortensen, 1990, cited in Kush).

<u>Suicidal Ideation</u> - thoughts or verbalizations of causing serious injury or death to oneself (Pfeffer, 1986, cited in Kush).

CHAPTER II

REVIEW OF THE LITERATURE

Magnitude of the Suicide Problem in Canada, with Specific Reference to Alberta

In this section, the statistical data pertaining to suicide is explored. Its aim is to quantify the magnitude of the suicide problem in Canada, with special reference to the Province of Alberta. Suicide is a tragic and perplexing phenomena which, in one way or another, touches the lives of many Canadians. Although suicide is a low frequency event, its prevalence among adolescents is not always fully appreciated by society, a situation that should cause great concern to all Canadians.

Adolescent Suicide Rates in Canada

In Canada, suicide is the second leading cause of death (following motor vehicle accidents) among youth aged 10-24 (SIEC, 1999; Health and Welfare Canada, 1995). It has been estimated that approximately 25 to 30 children under the age of 15, and approximately 700 young people between the ages of 15 and 24 commit suicide each year (Canadian Association for Suicide Prevention, 1994, cited in Wenckstern, Leenaars, & Tierney, 1995). In the early 1960's, the rate for suicide among youth aged 10-19 began to rise, and by the late 1970's had almost tripled (SIEC, 1999). Although it remained below the national overall rate, the rate for those aged 15-19 had begun to approach the general population rate of 13 per 100,000. The suicide rate for 10-14 year olds has also shown an increase but remains below 2.5 suicides per 100,000 (SIEC, 1999). Canadian Institute of Child Health (1995) however, reported that the rate of suicide for this age group has almost doubled over the last 30 years. When compared to the United States, Leenaars and Lester (1995) found the Canadian rate to be higher for

adolescents aged 15-19. Additionally, according to the United Nations report, Progress

of Nations (The United Nations Children's Fund, 1994, cited in SIEC, 1999), a

23-country study of suicides rates, showed that Canadian youth aged 15-19 ranked third

highest after New Zealand and Finland, while the United States ranked fifth.

Examination of these statistics has demonstrated that the suicide rate for adolescents

in Canada has continued to rise over the years. For example, in the past three decades,

the rate of suicide among 15-19 year old Canadians has increased significantly from 33

deaths (2.30 per 100,000) in 1961 to 231 deaths (11.53 per 100,000) in 1996 (CANSIM,

1999). When the rates are examined on the basis of gender, the increase becomes more

pronounced. The suicide death rate among teenage males has increased fourfold from

5.3 to 23 per 100,000 between 1960 and 1991 (Canadian Institute of Child Health,

1995). The rate among young females also increased from 0.9 to 4 per 100,000 between

1960 and 1991 (Canadian Institute of Child Health, 1995). These statistics indicate that

young males are at a much higher risk of completing suicide than young females. The

latest rates available from Statistics Canada published in 1997, show a total of 261

completed suicides for youth aged 15-19, (12.9 per 100,000); of these, 207 were male

and 54 were female.

Many consider suicide to be nearly non-existent among children under the age of 14.

However, statistics show that the number of deaths per 100,000 in the 10 -14 year age

group has varied from 1 in 1951 (.1) to 34 deaths (1.8) in 1992 (Health and Welfare

Canada, 1995). Although this rate is low, the statistics indicate it is still an area of

concern. For example, during the period 1993-1997, 229 Canadian children between the

ages of 5-14 completed suicide (SIEC Alert, 2000). Two of these were boys under the

age of 10. Of the remaining 227 children, 155 were male, and 72 were female. It has generally been assumed that children are relatively immune to suicidal behaviour. This belief is based on two widely-held notions; firstly, that childhood is relatively free of problems and stress, and secondly, that children do not have the developmental maturity to think of or act upon suicidal thoughts (Pfeffer, 1993, cited in SIEC Alert, 2000). Research however, has found that by grade 3, children aged 8-9 have a thorough understanding of suicide, and younger children understand the concept of killing oneself (Mishara, 1999, cited in SIEC Alert, 2000).

An examination of completed suicide statistics among young people in Canada during 1997 revealed the following data according to age group: 39 males and 12 females, aged 1-14; 207 males and 54 females, aged 15-19; 257 males and 36 females, aged 20-24 (Statistics Canada, 1997). These data show that a total of 605 young people under the age of 24 committed suicide in Canada in 1997. This is a disturbingly large number of young people to have died in the span of just 12 months. It is clear that Canadian youth, especially males between the ages of 15-24, are at an elevated risk for completed suicide. Other elevated risk groups include aboriginal and gay youth. It is important to note that these groups are at a considerably higher risk for suicide than the general population (Health and Welfare Canada, 1995).

According to researchers, the suicide rate for aboriginal youth ranges between two to five times higher than that of the general Canadian population (Canadian Institute of Child Health, 1995; Sakinofsky & Leenaars, 1997). In addition, it has also been estimated that suicides among gay youths in North America constitute between 5% to 30% of completed youth suicides annually. Gay youth are two to three times more likely

to attempt suicide than other young people in North America (Gibson, cited in Johnson, 1999). In Canada, research in this specific area is lacking. According to Health and Welfare Canada (1995), gay men are reported to be more likely to attempt suicide during their adolescent years, while lesbian women are reported to be more likely to attempt suicide at a later age.

Suicide Rates in Alberta For All Age Groups

In Alberta, there is reason for considerable concern about suicide deaths because the rate of suicide usually exceeds the overall Canadian rate. According to the Alberta Suicide Data Report (SEIC, 2000), suicide ranked as the second leading cause of death in 1997 for those under the age of 45. It also reported that an average of over 400 Albertans take their own lives annually. Suicide was the leading cause of injury death among Albertans in 1997, and accounted for over one-quarter of all injury deaths. More than 2000 Albertans took their own lives between 1993 and 1997. The percentage of completed suicide among males (77%) is higher than the female percentage (23%), however females (61%) attempt suicide more often than males (39%).

Alberta experienced its highest suicide rates during 1991 and 1992, with 18.8 and 18.7 per 100,000 respectively (Office of the Chief Medical Examiner, 1997, cited in Snihurowych, 1997). In 1997, 401 suicides were completed in Alberta, of which 98% (393) were by residents of the province. This translates to a suicide rate of 14.34 per 100,000, placing it second among the Canadian provinces (SIEC, 2000). The highest rate of suicide in Canada was in the province of Quebec, while the lowest rate was in Newfoundland.

Adolescent Suicide Rates in Alberta

In Alberta, the suicide rate within the younger age groups, especially those between the ages of 15-19, has been increasing over the past few decades, and corresponds to a similar trend nationally. In 1961, there were only 4 documented suicides among youth aged 15-19 (a rate of 4.04 per 100,000) (CANSIM, 1999). However, according to the Office of the Chief Medical Examiner, in 1991 (cited in White, 1995) the rate of suicide among Albertans aged 15-19 increased 39% (from 18.8 in 1990 to 25.45 per 100,000 - 46 deaths). When this rate is compared to the overall rate of 13.2 for the rest of Canada, the seriousness of the problem in Alberta becomes evident (White, 1995). Data for 1996 indicates the rate has dropped and levelled off at 15.23 per 100,000 (30 suicides) (CANSIM, 1999). Although the rate has dropped since 1991, it is still considered to be quite high.

An examination of the suicide rate among 15-19 year olds according to gender, indicates that completed suicide is more prevalent among males at 24.79 per 100, 000 (25 deaths) than females at 5.20 per 100,000 (5 deaths) (CANSIM, 1999). In the Capital Health Region during 1997, 6 suicides were documented for this age group (Alberta Center for Injury Control and Research, 1997) .

For youth aged 1-14, suicide is relatively rare. In 1961, only 2 suicides were reported for this age group giving a rate of .46 per 100,000 (CANSIM, 1999). By 1996 however, this rate had increased to 1.53 per 100,000 (9 suicides) (CANSIM, 1999). Gender difference is also evident in this age group, with a higher percentage of males (8 deaths) completing suicide than females (1 death) (CANSIM, 1999). Although, the numbers are relatively low, the fact that children so young commit suicide is very disconcerting.

Attempted Suicide in Alberta

The seriousness of the problem becomes more evident when one examines the rates of attempted suicide. Non-fatal suicide attempts are thought to occur at a significantly higher rate than completed suicides, especially among young people. Wenckstern, Leenaars, & Tierney (1995) reported that approximately 70,000 young people attempt suicide each year, while many others seriously consider it. Adolescent females are 4 to 7 times more likely to attempt suicide than adolescent males (Wenckstern, et al., 1995). This statistic indicates that a large number of Canadian youth are troubled, and are obviously not seeking, or are unable to find, the support needed to deal with their problems.

The frequency of attempted suicides is an important indicator for assessing overall level of suicidal behaviour across all age groups. For every death from suicide in Alberta during 1997, there were nearly seven hospitalizations due to attempted suicide, and over 17 emergency room visits for injuries sustained from self-inflicted injury (A summary of the Alberta Suicide Data Report: Alberta Center for Injury Control and Research, 2000). This report also indicated that attempted suicides are among the leading causes of injury-related, in-patient hospitalizations in Alberta each year. Between 1993 and 1997, more than 14,000 hospitalizations were recorded for self-inflicted injury. During 1997 alone, over 2650 Albertans were hospitalized with such injuries. In addition to hospitalizations, more than 6800 Albertans were treated in Emergency Rooms between April 1997, and March 1998 for injuries sustained during suicide attempts.

In the area of attempted suicide, there is an increasing concern for Albertas adolescents. According to the Alberta Centre for Injury Control (2001), 1229 youths,

aged 15-19, visited hospital emergency rooms for self-inflicted injuries during 1997. Of this number, 349 were from the Capital Health Region. Among children aged 10-14, the number of emergency room visits for self-inflicted injuries was 237, of which 68 occurred in the Capital Health Region.

With regard to the hospitalization of adolescents for-self inflicted injuries in Alberta during 1997, 434 cases were recorded for the 15-19 age group, and 151 for those 10-14 years of age (Alberta Centre for Injury Control, 2001). Of these, 71.5% were female. Within the Capital Health Region, 54 cases were reported among the 15-19 year olds, and 20 cases for those in the 10-14 age group (Alberta Centre for Injury Control, 2000). These numbers indicate that youth in Alberta are seriously troubled by thoughts of suicide.

Bland, Dyck, Newman, and Orn (cited in Leenaars, et al., 1998) conducted a study of attempted suicides in Edmonton over a one year period (1993-1994). They found the highest attempted suicide rate among 15-19 year olds, where a dramatic value of 805 per 100,000 was reported. Within this age group, females (217 attempts) were more likely to have attempted suicide than males (97 attempts). When these results were compared to parasuicide data from the WHO/EURO (the most comprehensive study of this area), it was found that for youth aged 15-24, Edmonton had the highest rate of suicide among the cities for which statistics were available.

It is suggested that the number of attempted suicides is also significantly higher than previously estimated. According to different authors, the ratio of attempted suicides to completed suicides, lies somewhere between 10 to 100, or even higher. As shocking as these statistics may appear, they do not represent a true picture of the magnitude of the

problem. Official reports tend to underestimate the incidence of suicide, and whenever possible classify suicide as accidental death (Duraj, 1984). In addition, no formal mechanisms are in place for reporting suicide attempts unless the individual is hospitalized.

Conclusions:

The statistics clearly indicate that suicide is occurring at an alarmingly high rate among the youth in Canadian society. Awareness of this fact must not be hidden, but should be elevated to a prominent level in all our communities. As unsettling as the suicide statistics are, they probably do not tell the whole story because such data usually understate the number of suicide cases (Cole & Siegel, 1990; De Man 1998; Garland & Zigler, 1993; Randell, Eggert, & Pike, 2001). Some of the reasons for this include: (1) many apparent accidents (car accidents, overdoses, drownings) may in fact have been suicides, (2) there may be underreporting of suicide cases because of the stigma associated with the act, and (3) there is a prevalent belief that young people, under the age of 14, are incapable of committing or attempting suicide (Cole & Siegel, 1990). It is important to remember that the accuracy of suicide rate statistics is often disputed, and has been a contentious issue since the earliest days of suicidology (Csapo, 1988). Although evidence indicates a dramatic rise in youth suicides since the 1950s, it is possible that rates were actually much higher in the fifties than reported. Some researchers argue that the current high suicide rate among youth may be partly due to (1) societies willingness to acknowledge that its youth do indeed commit suicide, (2) medical examiners being more likely to label a death caused by a self-inflicted injury as suicide, and (3) a more accurate system of data collection (Snihurwych, 1997). Whether

one is prepared to accept the statistics at face value or not, it is clearly evident, from even the most conservative estimates, that suicide is a serious social problem deserving of attention.

The School's Role in Suicide Prevention

The role of the school in suicide prevention is one that is open to debate; for example, some school officials question any responsibility beyond basic education, while others raise concerns about the possible liability with failure to provide a suicide response program (Kalafat, 1991). The belief that schools can play a role in suicide prevention however, is not a new one. In 1910, at the Vienna Psychoanalytic Society's Symposium on Suicide, Freud supported the position that schools should provide special support in the area of suicide prevention (Kush, 1991). According to many others, schools are ideal places to deal with the prevention of adolescent suicide (Kalfat, 1990; Lester, 1993; Malley, et al., 1994; Tierney, Ramsay, Tanney, & Lang, 1990). Support for this premise seems obvious because schools are found in almost every community, and students spend an average of 6 hours a day, for a major portion of a year in school. Lester (1993) states that because peers, teachers, and school counsellors are constantly in close contact with students they are in an ideal position to observe signs of impending suicide and to intervene before it happens.

Kalafat (1990) outlined three reasons why schools can be effective in the prevention of suicide.

1. Identification: school personal are in contact with students for more waking hours than any other adults in the community, and as such are in a position to notice changes in student behaviour.

2. <u>Support:</u> school personal are in a position to provide support for students experiencing difficulties.

3. <u>Education:</u> since education is the basic role of schools, facilities and an appropriate environment for instructing young people are already in place.

Students and staff can be taught to identify troubled students, and provide them with a support system where professional help is available. This will work of course, only if students contemplating suicide display detectable warning signs before an attempt is made. Shneidman (1985) states that most individuals who commit suicide give some verbal or behavioural clues regarding their thoughts or plans. While some of these clues may be subtle or in code, others are more obvious and people can be taught to detect them. In a school environment with trained staff, an excellent opportunity can be created to identify, intervene, and support at-risk youth (Kush, 1991).

Poland (1989) reported that the schools role in suicide prevention is quite straightforward. Schools should be able to detect suicidal students, assess the severity of suicidal thoughts or actions, notify parents of its concerns for suicidal students, and provide referral and follow-up support for students.

Klan (1991) provided the following reasons for including a suicide prevention program in schools.

1. Surveys indicate that friends are frequently contacted by adolescents contemplating suicide. Teenagers need to be able to recognize the potential dangers to themselves and their friends, and be educated to respond appropriately.

2. Most adolescents know someone who has attempted or completed suicide, and they want and need information on this topic.

3. Discussing suicide and learning ways to obtain and give help can reduce the incidence of suicide. Exposure to the topic does not induce suicidal behaviour; indeed the failure to talk about suicide makes it almost impossible to prevent.

4. Self destructive behaviour is actually a type of problem-solving. Children can be educated to generate options for solving their problems, and learn to cope with negative feelings.

5. Since schools are interested in the whole child, the teaching of life proficiencies, decision-making skills, personal safety aptitudes, family life skills, career development, homemaking, and stress management should be part of every student's education.

Smith (cited in Lester, 1993 p.154) has also suggested five reasons to justify the involvement of schools in prevention of suicide.:

1. Modern schooling involves more than teaching academic subjects; it also tries to help students develop into mature and productive citizens, and this typically includes efforts to develop good psychological health.

2. Schools try to resolve other problems (learning disabilities and obvious psychiatric problems) that interfere with education, and suicide is certainly among those listed in this category.

3. Schools have developed resources, such as counselling services, which are essential for suicide prevention.

4. Suicide prevention typically includes an educational component, and it can fit in well with the schools overall health program.

5. Law suits may result if a suicide prevention program has not been put in place.

Many schools tend to deal with suicide when a crisis situation actually develops. Schools must also play an active role in preventing the problem. According to Lester (1993, p. 153) "Schools could help children and adolescents develop the traits, habits, and skills that would make it less likely they will ever become suicidal." Schools also need to play a role in postvention, or the process of dealing with suicide once it has happened.

According to Dyck (1990, cited in Wenckstern, et al., 1995), the overall rationale underlying the school's role in suicide prevention is the assumption that people who are educated about suicide are more likely to be aware of the resources available during times of crisis. They will also be informed regarding the identification of suicidal individuals, and the basic intervention skills necessary to help. The fact that most adolescents attend school, makes the introduction of suicide prevention education an obvious course of action. Introducing such programs however, has not always been easy and has often met with resistance.

Dyck (1990, cited in cited in Wenckstern, et al., 1995) states that many of the obstacles to school-based suicide prevention programs arise from a lack of information and knowledge about suicide and its prevention. He asserts that the ten most common barriers to implementing a program are the following:

1. Belief that talking about suicide will increase the likelihood of suicidal behaviour.
2. Denial of youth suicide per se, as in statements such as "suicide does not happen in my school" or "suicide is not a problem here."
3. With the increasing curriculum demands being placed on teachers, there is little time left for issues outside the academic realm. In addition, the schools emphasis on

competition and academic excellence translates into the exclusion of mental health topics.

4. Teacher attitude toward suicide.

5. Insufficient helping resources.

6. Potential values conflict.

7. Potential concern from parents regarding suicide prevention.

8. Concern for adolescent feelings of responsibility in the identification of suicidal peers.

9. Common versus suicidogenic antecedents.

10. Insufficient proof of program effectiveness.

In conclusion, it is evident that many authors support the position that schools should play a role in the prevention of suicide. Schools however, cannot be expected to bear the sole responsibility in this regard; we need a network in which schools, community agencies, and parents work together to attain a common goal.

The Role of the School Counsellor in Suicide Prevention

School counsellors who work with young people will inevitably confront the issue of suicide, and many authors acknowledge the important role that school counsellors can play in its prevention. According to Stefanowski-Harding (1990) school counsellors are "on the front line for the identification, prevention, intervention, and postvention of suicidal behaviour". Smaby, Peterson, Bergmann, Bacig, Swearingen, (1990) assert that school counsellors are in a unique position to initiate prevention programs because of their daily contact with students and their knowledge of counselling principles. They also have the skills and knowledge necessary to help adolescents in need, to facilitate

group processes, and to direct students to the many community services available. According to Lester (1993), the most important role of school counsellors, in relation to suicide prevention, is their availability to students. Counsellors are accessible for eight hours a day, are knowledgeable about the thoughts and feelings of students, and are able to assist individuals in concrete ways.

Barrett-Hicks (1990) recommends training in the area of suicide for every school counsellor. For instance, they require specific training in the area of suicide prevention, intervention, and postvention. There appears to be a general consensus among authors regarding the types of training that school counsellors should receive to complement their role in suicide prevention. Following is a representative sampling of the training recommended.

1. School counsellors must have the ability to identify students who are at-risk for suicide. To do this, they require knowledge of the risk factors and warning signs of suicide (Capuzzi, 1988; Johnson, 1987; Johnson, 1999; Poland, 1989; Smaby, et al., 1990; Stefanowski-Harding, 1990).

2. Counsellors must become aware of the suicide problem in their school, and notify school officials about the seriousness of the problem (Smaby, et al., 1990).

3. School counsellors should be able to assess the lethality of the suicidal risk (Capuzzi, 1988; Johnson, 1999; Kirk, 1993; Poland, 1989; Smaby, et al., 1990; Stefanowski-Harding, 1990). "Lethality refers to the probability of a person killing him/herself, and is quantified on a scale ranging from low to moderate to high" (Leenaars & Wenckstern, 1994, p. 85, cited in Wenckstern, et al., 1995). Training in

assessment of lethality and suicide interviewing is strongly recommended (Barret-Hicks, 1990).

4. Counsellors must be aware of community resources and referral agencies that are available for continued care. They may also function as the resident consultant regarding student behaviour. In this capacity, they have to acquire the knowledge and information needed when teachers, parents, and students request assistance or information regarding suicide (Kirk, 1993; Stefanowski-Harding, 1990).

5. School counsellors can act as a liaison between the community and schools, between mental health professionals and teachers, and between suicidal teens and parents (Poland, 1989; Smaby, et al., 1990).

6. They are expected to be able to respond to a crisis and possess a knowledge-base regarding suicide intervention (Capuzzi, 1988; Johnson, 1987; Johnson, 1999; Poland, 1989). However, Johnson (1987) states that the role of the counsellor should not include long term intensive therapy. In such a case the student should be referred to an outside agency.

7. Regarding postvention, the counsellor must be able to provide individual and group counselling, deal with bereaved families and other parents, manage suicide crises, disseminate information to students, link individuals to community resources, and handle long term follow up (American Association of Suicidology, 1989, cited in Wenckstern, et al., 1995). Subsequently, knowledge and skills in the above areas is required.

As can be seen in the discussion above, the suicide prevention role of school counsellors can entail an enormous amount of responsibility, and this is in addition to the

administrative duties they may already have. In recognition of this fact, schools are advised to have mental health teams to deal with suicide prevention, and the school counsellor can be a member of this team (Capuzzi, 1988; Kirk, 1993; Poland; 1989).

Components of Comprehensive School-Based Suicide Prevention Programs

This section profiles the components of comprehensive school-based suicide prevention programs. These components provide the basis for the items in Part II (Programmatic Survey) of the questionnaire used in this study.

Comprehensive school based suicide prevention programs are based on the classical approach to the prevention of mental health and public health problems developed by Caplan (1964, cited in, Leenaars & Wenckstern, 1999), who differentiated between primary, secondary, and tertiary prevention. The more commonly used concepts for these three modes of prevention are prevention, intervention, and postvention (Leenaars & Wenckstern, 1999).

Comprehensive suicide prevention programs therefore, deal with all aspects of suicide prevention, and there seems to be some agreement about what the programs should contain. For example, they must include a system-wide policy that addresses prevention, intervention, and postvention (Tierney, Ramsay, Tanney, & Lang, 1990). More specifically, to be comprehensive, they must address suicide prevention prior to a suicide event, during the suicide crisis, and after completed suicides (Kush, 1991). Ryerson and Kalafat (1994) state that the goals of comprehensive school-based suicide prevention programs are threefold:

1. Prevention: to prevent the occurrence of the self-destructive behaviour, and completed suicides in the school community.

2. Intervention: to intervene swiftly, appropriately, and in a supportive manner when students are in a suicidal crisis.

3. Postvention: to assist the school community in trying to cope with the aftermath of a suicide completion.

The overall goal of such school-based response procedures is to interrupt the pathway to suicide at the earliest possible point along the continuum from individual vulnerability, through suicidal feelings, to suicidal behaviour (Kalafat & Elias, 1995). Kalafat and Elias (1995) further state that comprehensive programs try to ensure:

1. That persons who come into contact with potentially suicidal adolescents can readily identify them, know how to respond initially, obtain help rapidly, and be consistently inclined to take action.

2. That troubled teens are aware of, and have immediate access to, helping resources and may be more inclined to seek such help as an alternative to suicide.

Comprehensive programs also seek to be an ongoing, intact, and updated part of a school's student services (Kush, 1991). Many authors have discussed models of comprehensive school prevention efforts (Barret-Hicks, 1990; Calgary Board of Education, cited in Dickson, 1991; Canadian Association for Suicide Prevention, 1994, cited in Wenckstern et al., 1995; Capuzzi, 1988; Garfinkel, 1989; Kalafat, 1990; Poland, 1989; Tierney, et al., 1990). They all advocate multi-focussed comprehensive approaches. Malley et al. (1994) for example, in reviewing the literature concerning the features of recommended comprehensive school-based suicide prevention programs, found the following six broad areas most commonly identified. In addition, sixteen

specific sub-components were also identified within these areas in this study, and these are listed in Appendix A.

1. The formal construction of a suicide prevention program, and/or policy in school.

2. Thorough training of school personnel, and involvement with the community.

3. Prevention activities including education, screening, and supportive counselling for at-risk students.

4. Intervention programming with assessment of lethality, crisis management, and referral processes in place.

5. Postvention programming.

6. Program evaluation.

Each of these areas will be defined and briefly described in terms of their importance to a comprehensive school-based approach to adolescent suicide prevention.

Program Construction: Policies and Procedures

According to Poland (1989), gaining support from the top administrators in the school board is a key and initial step to constructing and implementing suicide prevention programs in schools. Miller and DuPaul (1996) maintain that in addition to support from administrators, it is imperative that support of school counsellors, teachers, and parents also be obtained. Without their support, preventative efforts are likely to fail.

To ensure effectiveness, researchers generally agree that schools must establish policies and procedures to guide suicide prevention, intervention, and postvention efforts. (Canadian Association for Suicide Prevention, 1994, cited in Wenckstern et al., 1995; Capuzzi & Gross 2000; Celeotta, 1995; Kalafat & Elias, 1995; Poland, 1989;

Tierney, et al, 1990). The schools position should be one of proactive prevention, with preparation and education being the keys to suicide prevention (Capuzzi & Gross, 2000). The importance of having written procedures to guide staff and to limit the responsibility of the school prior to the crisis, cannot be overemphasized (Poland, 1989). It is essential that schools be well prepared to assist students and staff who are affected by suicide, or non-fatal attempts of suicide (Tanney, 1995).

Capuzzi and Gross (2000) recommended that during the construction phase, schools draft a detailed and explicit policy describing the roles, policies, and procedures to be followed in its suicide prevention efforts. Furthermore, those involved with the program should be given the opportunity to provide input to policy formulation, and to make revisions and refinements. This involvement will help to insure that participants are not only aware of their roles and responsibilities, but are also more likely to support a policy they helped design. The policy draft should be checked, in advance of implementation, for legal and ethical implications.

During its design stage, each school should examine its own situation and develop a program that is in tune with its needs, and the resources available in the community (Kalafat, 1990; Poland, 1989). To aid school personnel in designing a program, examples of guidelines and procedures used by other school districts should be obtained and adapted to local conditions (Kalafat; 1990; Poland, 1989). Furthermore, consultation with an adolescent mental health professional should also be integrated into the initial stages of program construction (Kalafat, 1990; Kush, 1991).

According to Tierney, et al. (1990), policies must be approved by those responsible for leadership in the system, and written so that goals, objectives, and mandates are

clearly understood. A formal policy establishes the schools commitment to prevention efforts and makes that commitment evident to staff, parents, and students (Tierney et al., 1990). Well-written formal policies help reduce poor decision-making, indecision, and conflicts during times of crisis (Celeotta, 1995). Schools that do not have such written polices and procedures are ill-prepared to assist the staff and students when suicidal behaviour occurs (Tanney, 1995).

The policy should contain references to the activities and procedures involved with prevention, intervention, and postvention. Topics should include general information about adolescent suicide, intervention guidelines and procedures, plans for reporting incidents, ways to inform parents, the involvement of other resources, procedures for follow-up and postvention, along with a listing of all relevant community resources that may be needed for referral or consultation (Tierney, et al., 1990). This resource may be used as training material for staff, as well as providing immediate reference in times of crisis (Leenaars, et al., 1998). According to Kalafat and Elias (1995), the policy should also embody procedures for responding to at-risk students, dealing with suicide attempts and completions, and students returning to school after a suicide attempt. The procedures should clearly describe what school personnel are to do, and to whom they may turn for support in given situations.

In the Malley,et al. (1994) study, 51% of their sample in the United States reported having formal policies in place. They also found that schools with formal written policies/procedures tended to possess a greater number of the literature-recommended components for comprehensive suicide prevention programs. In contrast, a study by Hayden and Lauer (2000), which surveyed all school districts in Washington State,

found that the majority (66%) of districts did not have policies or procedures to deal with adolescent suicide in the schools.

Program Implementation: Staff Training and Community Involvement:

Comprehensive suicide prevention in schools is best accomplished by a team of school professionals who assume the task of initiating, co-ordinating, and managing the program. They must also be able and willing to take responsibility for assisting faculty and students during a suicidal crisis, and in the aftermath of a suicide (Barrett-Hick, 1990; Capuzzi, 1988; Johnson,1999; Kirk, 1993). This team should be multidisciplinary and include individuals such as the principal, school nurse, school counsellor, school psychologist, or selected teachers (Johnson, 1999). Team members must develop extensive knowledge of the process, and receive specialized training in the most effective strategies for prevention, intervention, and postvention along with the legal and ethical responsibilities (Kirk, 1993). The purpose of a team approach is to ensure that delicate decisions are not the sole responsibility of one individual, and that qualified persons are available as required (Capuzzi, 1988). As an auxiliary to the school team, outside mental health consultants should be invited to the school on an ongoing basis, to participate in suicide prevention procedures, and offer mental health counselling services to individual students and groups (Kalfat, 1991; Peck, Farberow, & Litman, 1985, cited in Kush, 1991).

It is generally accepted that schools are not expected to deal with adolescent suicide on their own. Dealing effectively with suicidal and troubled young people will, at times, require inputs that schools cannot reasonably provide (Tierney, et al., 1990; Capuzzi, 1988). Many researchers believe that school-based comprehensive suicide prevention

programs are most effective when they develop solid links to community organizations and agencies such as mental health centers or emergency hospital mental health units (Capuzzi, 1988; Kalafat & Elias, 1995; Johnson, 1999; Kirk, 1993; Poland, 1989; Tierney, et al., 1990). In this regard, the school with established referral procedures, allows educators to draw on these resources during times of crisis, and helps reduce the stress on individuals at the school (Johnson, 1999). Tierney et al. (1990) and Dyck (1990, cited in Wenckstern et al., 1995) assert that because of the emergency nature of a crisis, quick access to these resources is imperative. Accordingly, links to agencies should be established early, and a commitment to be available and participate in the management of a suicidal student obtained. Some of these community agencies may also be called upon to provide training for staff to prepare them to deal with suicide prevention.

Most authors agree that all school staff should receive some training in adolescent suicide through workshops or in-service programs (Canadian Association for Suicide Prevention, 1994, cited in Wenckstern, et al., 1995; Capuzzi, 1988; Miller & DuPaul, 1996; Health and Welfare Canada, 1995; Kalafat & Elias, 1995; Poland, 1989; Tanney, 1995; Tierney et al., 1990). These programs help staff to understand the causes, warning signs, and myths associated with adolescent suicide, and provide suggestions for dealing with suicidal students (Capuzzi, 1988). According to Capuzzi and Gross (2000), in-service training also provides an opportunity for staff to raise concerns and have questions answered.

Before prevention activities are undertaken with the students, staff must receive orientation on the schools policy for intervention, prevention, and postvention (Poland,

1989). Ideally, all faculty should receive an overview of the practical and relevant facts about suicide, the rationale for the schools prevention program, their specific roles and responsibilities in that program, the basic guidelines for making initial contact with troubled youth, an awareness of school and community resources, training in the recognition of potentially self-destructive behaviour in a classroom setting, and lessons in delivering curriculum awareness programs (Kalafat, 1990; Kalafat & Elias, 1995).

Tierney et al. (1990) recommend suicide awareness sessions for all staff who come into contact with students including teachers, administrators, secretaries, and cafeteria staff. As a minimum, teachers, who are usually the first to notice signs of trouble in the classroom, should know the warning signs of suicide so they can refer a student to the school counsellor (Johnson, 1987). Counselling staff should receive specialized training in the assessment of lethality, intervention, postvention, and referral procedures. The goal of staff training is the early identification of youth at-risk for suicide, and their referral to community resources (Tanney, 1995). Health and Welfare Canada (1995) maintains that staff training should make school personnel more comfortable with the management of suicidal students, without inducing a feeling of total responsibility.

Malley, et al. (1994) found that 42% of the schools they surveyed, provided staff orientation training on their suicide prevention policy/program; 51% of the schools provided in-service intervention/prevention training for their school counsellors, and 47% provided training for teachers on the detection of suicide warning signs. In addition, 67% had a mental health professional on the school site and 74% of schools had a mental health team. Hayden and Lauer (2000) found in their Washington state survey that only 46% of the schools offered in-service training.

School-Based Suicide Prevention Activities:

Suicide prevention includes any self-injury prevention or health promotion strategy, generally or specifically, aimed at reducing the incidence and prevalence of suicidal behaviour (Health and Welfare Canada, 1995). It involves the proactive planning of strategies and activities to keep specific problems or crises from developing in the first place (Capuzzi & Gross, 2000). School-based suicide prevention activities are directed at potential victims of suicide, and those who may be in contact with potential victims (Kalafat, 1991). The three school-based prevention activities reviewed in this section are classroom activities, psychometric screening, and mental health supportive programs for high-risk individuals and groups within the student population (Kush, 1991).

The most common approach to the prevention of adolescent suicide in schools involves direct communication with students about suicide through a curriculum class-based awareness program (Miller & DuPaul, 1996). The objectives of these programs are to make students aware of adolescent suicide, to train them to identify students who may be at-risk, and to provide information about the availability of community resources where help can be obtained (Galand & Zigler, 1993). Proponents of classroom awareness programs work under the assumption that students who know about suicide, its warning signs, and sources of help are more likely to ask for help, or refer others to that help (Berman & Jobes, 1995). Support for these programs is also based on findings which claim that teenagers are more likely to turn to peers, rather than adults, for support in dealing with suicidal thoughts (Hazell & King, 1996; Kalafat & Elias, 1994). If these assumptions are true, educated adolescents may be able to identify a suicidal crisis and help fellow teens to get professional assistance. This approach to

suicide prevention has generated considerable debate, and a conclusive answer regarding its validity is still far from being attained.

Suicide awareness education is typically offered at the junior and senior high school levels (Tierney et al., 1990; Shaffer, Garland, Gould, Fisher, & Trautman, 1988). A typical program may vary, in length, from one class period to several hours (Miller & DuPaul, 1996). Kalafat (1991) recommends that the program be built into the current health curriculum. Course leaders are typically psychologists or social workers recruited from local mental health centers, or trained educators within the school itself (Miller & DuPaul, 1996; Shaffer, et al., 1988). With their specific focus on suicide, these programs seek to create a greater understanding of the subject and help students deal with their own feelings and those of others concerning the many manifestations of suicide ideation and behaviour (Tierney, et al., 1990). The programs are comprised of student attitudes, knowledge, and skills concerning suicide and its management. In the skills area, students learn to identify the warning signs of suicide, how to talk with a friend who may be suicidal, which community resources may be called for assistance, and even some problem-solving training (Garland & Zigler, 1993; Kalafat & Elias, 1995; Tierney et al., 1990). Many classroom suicide prevention programs distribute wallet-size cards, or pamphlets containing facts about suicide, its warning signs, steps to take if one suspects that a friend or family member is suicidal, and local telephone numbers of hotlines and community groups for immediate or emergency referrals (Kalafat, 1991; Shaffer, et al., 1988). In addition, some schools distribute prevention pamphlets to parents.

Comprehensive school suicide prevention programs make suicide awareness and education a mandatory part of the program (Tierney, et al., 1990). Capuzzi (1988, cited in Kush, 1991) asserts that media coverage of suicide does not usually include adequate educational content, and some media programs actually romanticize suicide. For this reason, it is essential that schools accurately and emphatically address the issue by utilizing well-planned presentations with competent speakers. The Calgary Board of Education has made suicide prevention units mandatory in the 9th and 11th grade curriculum (Tierney, et al. 1990) . Malley, et al. (1994) found 42% of schools provided in-class discussions on suicide, 50% of schools distributed materials on suicide prevention to students, while only 28% distributed materials to parents.

Case finding through direct screening of students is another prevention strategy which has been receiving increased attention. A variety of screening approaches have been proposed to identify at-risk students and provide them with assistance. Typically, school screening involves administering a questionnaire, or other screening instrument, to assess the presence of risk factors known to be associated with suicide; for example, depression, alcohol/substance abuse, recent and frequent suicidal ideation, and past suicide attempts (Berman & Jobes, 1995; Gould & Kramer, 2001). Students who score above a certain cut-off point are identified and might be referred to a school guidance counsellor who would look for further signs of risk (Berman & Jobes, 1995). The information gathered in this way, can be combined with other data to identify youth at-risk for suicide (Kalfat & Elias, 1995). In this analysis, Kalafat and Elias suggest the importance of including information on significant behavioural changes, any drop in school performance, withdrawal from social activities and contacts, and significant

losses. The assessment must also include additional information obtained from parents, teachers, and possibly from an interview with the student (Garfinkel, 1989).

Many screening instruments are available to measure suicidal history. Those most widely used include "The Suicide Behaviour Questionnaire" by Linehan and Nielsen, (1981), "The Reasons for Living Inventory" by Linehan, Goodstein, Nielsen, & Chiles, (1983), "The Suicide Ideation Questionnaire" by Reynolds (1987), and "The Suicide Intent Scale" by Beck (cited in Range, 1993)". Whenever screening is carried out, it should employ validated instruments administered by qualified, experienced professionals, and be part of a comprehensive program that allows for follow-up and intervention (Kush, 1991). Screening can provide the school with early identification of troubled individuals, and allow for closer monitoring and evaluation (Kalafat & Elias, 1995). It may also be used as a starting point to identify students who may benefit from mental health supportive programs. Malley, et al. (1994) found only 19% of schools employed screening to identify at-risk youth. Tanney (1995) stated that school-based screening programs are almost non-existent in Canadian schools.

The availability of individual and group counselling sessions, is an important element of school-based suicide prevention programs. Theses interventions can help students improve their coping skills and to become part of a support system within the school (Capuzzi, 1988). Capuzzi maintains that students who are potentially at-risk of suicidal behaviour should be encouraged to become involved in these sessions. Counselling provides an opportunity for high risk groups to develop life skills that enhance protective factors such as positive self perceptions, improved problem-solving abilities, and stress management techniques (White, 1995). The group sessions can also

create an opportunity for youth to form relationships with other youth in the school. Although counselling is not intended to be a substitute for long-term treatment for suicidality (Kush, 1991), it may nevertheless help at-risk students prior to a crisis, and enhance the likelihood of averting a possible suicidal outcome later on (White, 1995). The success of these special counselling programs depends on the availability of people who are trained in both individual and group counselling techniques and who can commit themselves to the time required to conduct the sessions. Malley, et al. (1994) found that the majority of schools (87%) provided counselling for at-risk students.

Intervention Programming for At-Risk Students:

Suicide intervention consists of the treatment and care given during a suicidal crisis or a suicidal problem (Kush, 1991). Leenaars and Wenckstern (1999) assert that, by definition, suicide intervention means the evaluation and management of a crisis situation. Within the schools, it infers that systems are in place to provide immediate help to students at-risk of suicide, that policies and procedures to mandate and guide such interventions have been established, that appropriate referral links with community resources have been fashioned, and follow-up with students is being maintained (Tierney et al., 1990). Suicide intervention procedures should be clearly outlined and described within the school's general suicide prevention policy (King, 1999; Tierney et al., 1990).

School-based intervention strategies generally involve a process in which potentially or apparently suicidal youths are identified and their situation systematically managed (Kush, 1991). Stefanowski-Harding (1990) asserts that interventions with suicidal youth can be divided into two phases. During the first (acute) phase, an assessment of lethality and the strength of family resources is carried out to help ensure that the student is safe.

The second stage is long term therapy. School-based interventions are generally found in the first phase while outside mental health agencies are responsible for longer term treatment in the second stage. Leenaars and Wenckstern (1999) emphasize the importance of community resource links because all at-risk youth cannot be treated by the limited resources found in a school system.

For suicide intervention to be effective, potentially suicidal students must be identified. Because of their unique position, school staff are in an excellent position to recognize the signs of potential suicidal behaviour (Tierney et al. 1990), but they must receive adequate training in the recognition of the warning signs of adolescent suicide.

The first step in suicide intervention is for trained staff to assess the severity of the risk, and then apply appropriate intervention (Pagliaro, 1995). Accurate assessment demands knowledge of the factors that put an adolescent at risk, as well as the behaviour and symptoms that adolescents may actually display (Kirk, 1993). To make this assessment, counsellors should possess good counselling and interpersonal skills, and be able to communicate with adolescents in a sensitive but therapeutic manner. Risk level assessment is crucial to the intervention process because it guides the intervenors approach to the adolescent, and determines what procedures will be employed during intervention (Kirk, 1993). Kirk points out that although both the high risk and low risk individual are expressing a wish to die, a low risk adolescent may benefit from regular sessions with a school counsellor (who is in consultation with an outside mental health professional), whereas the high risk student may require hospitalization to prevent completion of the act.

Ward (1995) states that intervention counselling should focus on the immediate prevention of self-harm, and the stabilization of the students present level of coping. This involves the discussion and exploration of feelings about how the crisis is affecting the student. Wenckstern et al. (1995) state that the goal of intervention counselling should be to lower the risk of suicide. They stress the importance of expanding the options available to the student for resolving their difficulties, so that alternatives to suicide become apparent. Raymond (1991, cited in Wenckstern, et al., 1995) points out that school intervention counselling is aimed at stopping the immediate crisis, not solving all the persons problems. A referral to another community professional is indicated when assessment reveals a high suicide potential.

Leenaars and Wenckstern (1993, cited in Wenckstern, et al., 1995) state that professionals working with suicidal adolescents must be reminded that every youth suicide cannot be prevented, and that there will be casualties. In a study conducted by Malley, et al. (1994), it was found that only 35% of schools had written statements describing the specific criteria to be used for assessing suicide lethality.

Postvention Programming:

The death of a student by suicide is one of the most difficult things for a school to have to face. Postvention, a term introduced by Shneidman (1985,cited in Leenaars & Wenckstern, 1999), refers to those co-ordinated services and activities that are designed to assist students, parents, friends of the deceased, and school staff to cope with the aftermath of a student suicide. Because the aftermath is an extremely stressful time, it is important that there be standardized procedures and practices in place before an actual suicide occurs (King, 1999). Leenaars and Wenckstern (1999) assert that it is essential

that procedures be clearly outlined in the school's policy. Having a clearly written plan will help to prevent hysteria and confusion during a crisis (King, 1999).

Leenaars and Wenckstern (1993, cited in Wenckstern, et al., 1995) maintain that postvention is a complex process, involves more than a single debriefing session with students, and is more than just grief counselling.

The danger of contagion or cluster suicides, involving vulnerable students, is a major concern following a suicide in the school (Leenaars & Wenckstern, 1993, cited in Wenckstern, et al., 1995). Contagion, with identification and modelling as the two primary contributing factors, is the most urgent concern in a postvention effort (Celotta, 1995). In the process of identification, the adolescent believes he/she is similar to the deceased in certain ways and has experienced similar problems. In modelling, youth begin to examine the positive effects of the death. Such positive results include the tendency of people to talk about suicide victims and feel sorry for them, the potential of becoming a school hero if school is cancelled for a day, or the possibility of having a yearbook dedicated to their name. Some youths may try to copy the victims action as a means of obtaining similar positive responses (Celotta, 1995).

To help prevent contagion among the student population, specific details about the victims character, problems, or suicide method should not be presented to the student body (Celotta, 1995). It is important to display concern for the student, without glamorizing or romanticizing suicide (Celotta, 1995; King, 1999). Actions such as establishing a permanent memorial to the student, planting a tree in their honour, or presenting a plaque should be avoided (King, 1999). King suggests that holding a moment of silence or placing a photo of the student in the yearbook is more appropriate.

Students should be informed of the event in small classroom groups, and loud-speakers,

or an assembly environment should not be used (Celotta, 1995; King, 1999). An

advantage of the classroom setting lies in the teachers ability to monitor student

response, answer questions, and refer some students for counselling. In addition, drop-in

support/crisis groups for students should be established in convienient locations

throughout the school. The library, conference room, or cafeteria are all suitable places.

Teachers should inform students about these services, and any student who wishes to

attend should be permitted to do so. Students should be encouraged to express their

feelings, but it must be realized that everybody reacts to death in different ways (Celotta,

1995). In the Malley, et al. (1994) study, it was reported that only 35% of schools had a

postvention component in place.

Program Evaluation:

Evaluation is the final area of a comprehensive school-based suicide prevention

program. Many researchers stress the importance and necessity of including an

evaluation component in any prevention program (Canadian Association for Suicide

Prevention, 1994, cited in Wenckstern et al., 1995; Capuzzi & Gross, 2000; Kalafat &

Elias, 1995; Poland, 1989; Tanney, 1995; Tierney et al, 1990). Tanney asserts that

programs need to be monitored to ensure they have been implemented according to their

design, that they are not harming anyone, and that they are achieving what they were

intended to achieve. Capuzzi and Gross (2000) recommend that evaluation procedures be

planned prior to program implementation. They further state that this component is

often overlooked in many programs. For instance, Malley, et al. (1994) found that only

15% of schools surveyed had an evaluation component. Tierney, Ramsay, Tanney, and

Lang (1990) assert the use of quantitative and qualitative methods of inquiry to obtain the most comprehensive evaluation results. The resulting data can be used to modify and improve the services offered, and provide justification for continued funding and commitment to other needed resources (Capuzzi & Gross, 2000).

In conclusion, school based suicide prevention programs are continually evolving, and developers should strive to keep up-to-date with the most recent empirical research in the area of adolescent suicide. As knowledge in the field continues to grow, programs will have to be updated, modified, and revised in accordance with the best evaluation research available, and the needs identified by on-site evaluation data. This kind of proactive approach is essential if suicide prevention programs are to succeed.

The Effectiveness of School-Based Suicide Prevention Programs

Are school-based suicide prevention programs effective? This is a hotly debated question, but one that must be addressed before a decision to implement a program can be made (Miller & DuPaul, 1996; Hazell & King, 1995; Overholser, Hemstreet, Spirito, & Vyse, 1989). Research articles dealing with their effectiveness are few and many studies have been poorly designed without control groups (Hayden & Lauer, 2000).

According to Leenaars and Wenckstern (1999) there has been no systematic examination of comprehensive school-based suicide prevention programs. Some studies have dealt with individual facets of these programs, but none have considered the subject as a whole. Following is an examination of the evaluation literature with some of the most commonly discussed aspects highlighted.

The vast majority of research has dealt with the effectiveness of class-based suicide awareness programs. The goals of these programs are to increase student-awareness of

adolescent suicide, to train students to identify others who are at risk, and to provide information about the availability of community resources (Garland & Zigler, 1993). These programs have sparked a considerable amount of debate. This can be attributed to: (1) the old myth that talking about suicide may indeed encourage it (Kalafat, 1991); (2) the belief that students who are not suicidal should not have to go through such programs (Shaffer, et al., 1988); (3) the view that education about suicide may lead to an increased use of manipulative suicidal threats to gain attention (Spirito, Overholser, Ashworth, Morgan, Benedict-Drew, 1988); and (4) the finding that only a minority of students hold views requiring intervention that is, students are generally knowledgeable about suicide prior to participation (Shaffer et al 1990). In defence of awareness programs, Kalafat (cited in, Hazell & King, 1996) argues that these programs are not aimed at students as victims but at students as helpers. The rationale for this line of thinking is based on research which shows that adolescents are more likely to seek support, regarding suicidal thoughts, from their peers rather than adults (Hazell & King, 1996; Kalafat & Elias, 1994).

There is some evidence that school-based suicide awareness prevention programs may not be fully effective (Popenhagen & Qualley, 1998). Clark (1993, cited in Popenhagen & Qualley, 1998) states that the majority of these programs are out-of-date, are not based on empirical research, and are modelled after a universal stress vulnerability model (the notion that suicide is simply a response to a stressful situation). Some researchers have reported no real advantages (Shaffer, Garland, Vieland, Underwood, & Busner, 1990), or detrimental effects (Shaffer et al 1990; Overholser, et al., 1989) to participating in suicide awareness curriculum programs. As a matter of fact,

Overholser et al. (1989) noted that male students displayed small but significant increases in levels of hopelessness, less appropriate evaluative attitudes, and an increase in maladaptive coping responses after taking a curriculum program. As a result of these findings, Overholser, Evans, & Spirito (1995) have argued that programs need to be substantially reviewed. Perhaps the programs should be gender specific because they seem to be more beneficial to females, but not to males who represent a greater risk for suicide. Shaffer et al. (1990) found that high-risk students (youth with reported histories of prior suicide attempts), endorsed more negative attitudes and beliefs about suicide and expressed more negative responses to school-wide suicide prevention programs than youth with no previous history of attempts.

Additional criticism of the curricular approach to suicide prevention include the following:

1. The majority of these programs subscribe to the idea that suicide is generally a reaction to extreme stress and as such everyone is potentially susceptible (Garland & Zigler, 1993). Garland, Shaffer, & Whittle (1989) found that 95% of the programs surveyed (n=115) in the United States employed the stress model of suicide. By employing this model some researchers have suggested that it de-stigmatizes suicide, in effect normalizing and making more acceptable the very act they wish to prevent (Garland & Zigler, 1993).

2. It has often been assumed that education and prevention are synonymous, and that education alone can produce behavioural changes (Miller & DuPaul, 1996). This contention, which forms the foundation for suicide prevention awareness programs,

has not been proven because research into suicide prevention curriculum programs has concentrated on changes in knowledge and attitudes rather than on behaviour.

3. Research on imitation suggests that it may inadvertently be stimulated by the format used in some presentations (Velting & Gould , 1997 cited in Gould & Kramer, 2001). For instance, the use of print or visual media in case history presentations, may lead some students to identify with the cases, and see suicide as the logical solution to their own problems.

4. Some researchers suggest that the peer networks of suicidal youth are not as extensive as those of non-suicidal youth (Hazell & King, 1996). If this is so, then educational programs designed to increase peer ability to recognize high risk peers, may not be an effective strategy to identify high-risk youth (Gould & Kramer, 2001).

Advocates however, suggest that awareness programs are useful for educating students about suicidal behaviour and its prevention. Several studies have reported an increase in knowledge (Barrett, cited in Poland, 1989; Kalafat & Elias, 1994; Spirito, Overholser, Ashworth, Morgan, and Benedict-Drew 1988), a change in attitudes (Barrett, cited in Poland, 1989 ; Ciffone, 1993; Kalafat & Elias, 1994), and a willingness to seek out help for peers or self (Barrett, cited in Poland, 1989; Ciffone, 1993; Kalafat & Elias, 1994) as a result of participating in curriculum programs. In addition, Kalafat and Elias (1994) found that students in general reported the programs to be useful. Evidence therefore exists that the programs have some benefits. More research however, is required to determine the best approach for their implementation. Kalafat encourages a strictly educational approach to the presentation of material, and the avoidance of an emotional context or tone (cited in Hazell & King, 1996).

Some authors suggest that given the controversy surrounding the effectiveness of suicide awareness programs, they might be improved by broadly focusing on mental health issues such as substance abuse, coping and conflict resolution skills, stress management, communication, and self-esteem enhancement (Eggert, Thompson, Herting, & Nicholas, 1995; Garfinkel, 1989; Spirito & Overholser, 1993). Suicide prevention would be presented as a component within this larger framework. Additionally, prevention programs that focus on general mental health issues (social skills training, problem solving skills, coping skills) may be applied to a variety of life problems, and may in fact be more beneficial than focusing solely on suicide (Gould & Kramer, 2001). Unlike suicide awareness programs, these programs would not focus directly on suicide, but help to stimulate positive mental health instead. The proponents of this approach believe that youth who are educated in these basic skills will be more immune to suicidal feelings and other life problems (Gould & Kramer, 2001). Eggert et al. (1995) implemented a life skills training session for at-risk youth and reported positive results. Their program concentrated on training in the following four life skills: self-esteem enhancement, decision-making skills, personal control, and interpersonal communication skills. They reported a decrease in suicidal risk behaviour, depression, hopelessness, and stress, and an increase in protective factors such as self-esteem, support resources, and feelings of personal control.

Suicide prevention educational programs that have been directed towards educators rather than targeting students appears to be a more effective approach (Gould & Kramer, 2001; Garland & Zigler, 1993). For instance, Tierney (1994) evaluated a training program which focused on the suicide intervention abilities, knowledge, attitudes of a

group of community helpers. The program consisted of a two day suicide intervention training program, and showed that helper intervention skills significantly improved after the session. Shaffer, Garland, Whittle, Underwood, (1988, cited in Garland & Zigle, 1993) also reported that educators who attended a brief (2 hour) program, showed a significant increase in their knowledge of suicide warning signs and the availability of community mental health resources. Furthermore, Mackesy-Amiti, Fendrick, Libby, Goldenberg & Grossman (1996, cited in Gould & Kramer, 2001) found that school personnel, after completing a suicide postvention training program, demonstrated an improved ability to cope with crisis situations. It seems that education programs directed towards teachers and counsellors (regarding the identification and referral of children at risk for suicide) show more promise of success than programs directed towards students.

Evaluation research in the area of screening students for suicidal risk is limited (Hayden & Lauer, 2001). Some researchers have reported that questionnaires are useful for identifying at-risk youth in the school environment (Eggert, Thompson, Herting, & Nicholas, 1995; Kirk, 1993; Poland, 1989; Reynolds, 1991; Reynolds, 1999). Opponents of this method point out the hazards of using screening devices to predict individual behaviour, and refer to them as being "sensitive but not specific" (Felner & Felner, 1989, cited in Kalafat & Elias, 1995). Kaufman and Zigler (1989, cited in Garland & Zigler, 1993, p.179.) warn that "standardized instruments are unable to measure or detect the complexity of behaviour. They cannot take into account the effects of changing events or of compensatory factors as well as risk factors." A limitation of this method lies in its tendency to generate a large number of false positives.

In summary, it would appear that there is no clear consensus on the effectiveness of school-based suicide prevention programs. It is now generally agreed however, that school-based programs must go beyond curricula for students and educators and include assessment and interventions (Kalafat & Elias, 1991). Garfinkel (cited in Miller & DuPaul, 1996) has suggested that curriculum programs alone may be ineffective because they omit several important components of suicide prevention such as early identification and screening, evaluation, educational programs for teachers, counsellors and parents, community linkage, postvention procedures, and comprehensive evaluation of suspected suicidal students. In light of the limitations of the various individual methods, more comprehensive preventative measures must be found. The literature does not appear to be consistent in defining what these measures should be, and further research must be carried out to explore the possibilities.

Summary of the Malley, Kush, and Bogo (1994) Study

The purpose of this final section is to provide an overview of the most salient findings of the Malley et al. (1994) study which provided the basis for the current study. Malley et al. (1994) conducted a study of a random sample of 325 secondary school counsellors in the United States. The purpose of the study was to determine to what extent the surveyed schools were implementing the 16 components of a Comprehensive Suicide Prevention Program. In addition, they examined whether having a formal written policy/program was related to having more of the literature-recommended 16 components in place in the school. Results revealed that the most common components implemented in the schools were mental health counselling to at-risk students (87%), having a mental health team on site that deals with students' mental health issues (74%),

and having a mental health professional on site as a consultant (67%). Likewise, components that were found to be lacking in the schools were: evaluation procedures for the program (15%), psychological screening programs (19%), prevention materials for distribution to parents (28%), and written criteria for counsellors to assess the lethality of a potential suicide (35%).

It was also found that half of the schools in the survey employed formal written suicide prevention policies/programs (51%). Furthermore, results revealed that schools with formal policies/programs had a significantly higher number of the recommended components in place, with the exception of mental health counselling to at-risk students, and psychological screening programs. The implication of this finding is that schools are more likely to have a comprehensive approach (containing the 16 components) to adolescent suicide prevention if a formal suicide prevention policy/program is in place to guide their actions and procedures. This study supports the benefits and importance of having a formal program in place to guide suicide prevention efforts and practices.

CHAPTER III

METHODOLOGY

<u>Participants:</u>

The participants in this study were professional school counsellors (n = 23) from

three Edmonton and area school districts (Elk Island Public Schools, Edmonton Catholic

Schools, and St. Albert Protestant Schools), and a group of student school counsellors (n

= 15) who were working towards their Master's degree in School Counselling at the

University of Alberta. The student counsellors were teachers also working in the school

system in a counselling capacity. The size of the sample utilized in this study was 38,

with each school counsellor representing one school facility. The participants consisted

of 15 (39.5%) males, and 23 (60.5%) females. With regard to their experience as school

counsellors, 18 participants (47.4%) had 1-5 years experience, 13 (34.2%) had 6-10

years, 3 (7.9%) had 11-15 years, and 4 (10.5%) had 16-22 years experience. Their level

of education was as follows: 15 participants (39.5%) possessed a Masters of Education

degree, 12 (31.6%) held a Bachelor of Education degree, 7 (18.4%) a Bachelor of

Education After degree, 3 (7.9) had a doctoral degree, and one individual did not answer

the question.

<u>Instrumentation:</u>

The survey instrument used in this study utilized the questions developed by Malley,

Kush, and Bogo (1994). There were 25 questions in total. Part 1 of the questionnaire

asked the participants to provide demographic information. It requested specific

information regarding the subject's school district, the number of years the participant

had practised as a school counsellor, their gender, and the highest level of formal education they had completed.

Part 2 of the survey asked for information about the suicide prevention programs operating in the participants' school district, and included articles with the 16 components identified by Malley et al. (1994) as being essential to any comprehensive suicide prevention program. Each of the questions in this section represented one component in a Comprehensive Suicide Prevention program. Participants were asked to respond to the presence or absence of each component in their school by answering *yes, no, do not know, or does not apply (school has no policy)* to the questions. Respondents were asked to complete this section without referring to their school documents.

The remaining items in the survey were developed by the researcher, and were based on a review of the literature. These items were designed to ascertain the goals of the schools suicide prevention program and whether or not suicide was discussed in the classroom. The counsellors were also asked to comment on, or provide recommendations for, any changes he/she might like to see in the way their school dealt with suicide. Finally, the counsellors were asked to express their feelings regarding their personal state of preparedness to deal with suicide. This question was based on the Kush (1991) and King (2000) studies carried out in the United States.

Included with each set of survey instruments was a cover letter explaining the purpose of the study, a form showing that permission had been obtained (from the school district) to conduct the research, and a "Consent to Participate Form" which was to be signed by each participant. All documents and instruments utilized in this study have been included in the Appendix B.

Procedure

Copyright permission, to use the items identified by Malley et al. (1994) as essential

to any comprehensive suicide prevention program, was obtained from Patrick B. Malley

via e-mail. Once ethics approval was received from the University of Alberta, a

Co-operative Activities form which is an application requesting permission to conduct

the study in the schools was submitted to the Office of the Dean of Education at the

University of Alberta. The application was then sent by this office to each of the

individual school districts. Once ethics approval and permission from each of the

respective school districts was secured, a list of all junior and senior high schools in the

participating school districts was acquired. School counsellors were then contacted by

phone. For schools with more than one school counsellor, only one counsellor was

asked to complete the questionnaire. The counsellor was chosen on the basis of

availability. Therefore, each school counsellor represented one school within the district.

The purpose of the study was explained to them and they were told that a section of the

study would be asking for their personal perspective on suicide prevention. After this

explanation was given, the subjects were asked if they were interested in participating in

the study. If they agreed, a survey package was mailed to them. The package contained

an introductory letter, a consent form for the participant to sign, the questionnaire, proof

of the school boards permission to conduct the study, and a stamped returnable envelope

(see attached forms). The counsellors were asked to complete the questionnaire by a

specified date, and return the package to the primary researcher by mail. If the package

had not been returned by one month following the specified date, a reminder phone call

was made. Following this reminder phone call, an additional waiting period of three weeks was given, after which time data analysis began.

An attempt was made to contact 52 junior and senior high schools within the 3 districts. In situations where counsellors could not be contacted initially, voice-mail messages were left and one follow-up call was made in an attempt to establish contact. Among the 52 schools, communication was eventually established with 36 school counsellors. All of these agreed to participate in the study, and eventually 23 surveys were returned for a response rate of 63.9%.

In addition to the school counsellors described above, 15 student school counsellors working towards their master's degree in School Counselling at the University of Alberta, completed the survey during class time. They were provided with the same information given to the 36 school counsellors. To ensure that the student counsellors were not providing information on schools already covered in the mail-out survey, a list of the schools was attached to their questionnaire. Respondents were asked to mark their survey with a star, if they were providing information on one of the listed schools. One questionnaire was returned with a star on it, so that questionnaire was not included in data analysis.

Data Analysis

The data in this study were analysed using both descriptive statistical methods, and question content analysis. Descriptive methods were chosen to describe the extent to which the surveyed schools implemented the literature-recommended components for suicide prevention. The statistical computer program, SPSS was used to analyse the descriptive statistics. Question content analysis was employed to summarize written

responses and identify common themes, trends, concerns, and activities reported by the

school counsellors (Fraenkel & Wallen, 2000). Each question was examined separately,

and data were reported in group format only.

Data for Research Question 1 was analysed using a direct frequency distribution

(percentage computation) of the responses to Item #1, #2, #3, #15, #16, and #17 in Part II

of the questionnaire. Data for Research Questions 3 and 4 were also analysed using a

direct frequency distribution (percentage computation) of the responses to Item #19 and

#20. Data for Research Question 2 was analysed using a frequency distribution of the

responses to Items #1 through 17 in Part II of the questionnaire. Each of these items

addressed a specific component of the literature-recommended comprehensive approach

to school-based suicide prevention. A percentage calculation was made to describe the

number of schools which had implemented each component of the suicide prevention

program, those which had not implemented each component, and those where it was

unknown whether each component was being implemented. These results are

summarized in Table 4

Data for research Question 4, 5, and 6 were analysed using a form of content analysis

called question analysis (Morse & Field, 1995) of the counsellors written responses to

items # 20, # 21, and # 18. The written responses were sorted according to item

number. For instance, all of the responses to item # 20 were organized into one area.

From this sort responses were coded and placed into categories. The responses were

used to explore common ideas, activities, and concerns among the counsellors.

Finally, the data were assessed in order to respond to each research question. The

results were used to evaluate the "state of reality" regarding school-based adolescent

suicide prevention programs in the selected Edmonton and area schools. Findings were reported along with apparent conclusions, limitations of the study, and recommendations for further research. Brief summaries of the findings on each item on the survey will be mailed to each school district participating in this study.

CHAPTER IV

RESULTS

In this section of the report, the data generated were used to fashion a response to each of the research questions originally posed by this research project.

Research Question 1: Using the school counsellor reports as a basis, how many schools in this survey currently have a formal written suicide prevention policy/program in place? Does this policy contain the literature recommended items for an efficient policy?

Table 1 indicated that a minority 7 (18.4%) of the schools surveyed had a formal written suicide prevention program/policy in place. Table 2 shows of these, 6 (15.8%) reported that their policy contained written procedures to address at-risk students, 2 (5.3%) provided staff in-service training and orientation to the policy, 6 (15.8%) included a written postvention component in the policy, 3 (7.9%) contained a written statement describing specific criteria for counsellors to assess the lethality of a potential suicide, and only 2 (5.3%) contained a written program evaluation component. These results suggest that there is room for improvement in some areas of the written polices.

Table 1

Schools That Have a Formal Written Suicide Prevention Policy/Program

	Suicide Prevention Component Present					
	Yes		No		Do Not Know	
Component	n	%	n	%	n	%
1. Written Formal suicide policy statement	7	18.4	27	71.1	4	10.5

Table 2

Schools Having the Recommended Written Components Within Their Policy

Suicide Prevention Component Present

Component	Yes		No		Do Not Know		No Policy	
	n	%	n	%	n	%	n	%
1. Written procedures to address at-risk student in policy	6	15.8	1	2.6	4	10.5	27	71.1
2. Staff in-service training and orientation to the policy/program	2	5.3	5	13.2	4	10.5	27	71.1
3. Postvention component	6	15.8	1	2.6	4	10.5	27	71.1
4. Written statement that describes specific criteria for counsellors to assess the lethality of a potential suicide.	3	7.9	2	5.3	6	15.8	27	71.1
5. Written policy that describes how the program is to be evaluated.	2	5.3	3	7.9	6	15.8	27	71.1

Research Question 2: How do the descriptions of the components of the adolescent

suicide prevention programs in the surveyed schools compare to

the literature recommendations for a comprehensive school-based

adolescent suicide prevention program?

Table 3 shows the number of literature recommended components implemented in

each of the schools. Following are some of the most salient observations from this data.

- It is evident, upon examining this table, that there is a considerable range in the data,

  with schools having as few as 1 of the components to as many as 15.

- None of the schools had all of the 16 components.

- 55.3% (n = 21) had less than half (8 out of 16) of the recommend components in

  place .

- Only a minority (7.9%) of schools reported having more than 10 components in

  place.

Table 3

Summary of the Number of Components the Schools Have in Place

Number of Components	Schools	Percentage
0	0	0
1	1	2.6
2	5	13.2
3	1	2.6
4	6	15.8
5	2	5.3
6	5	13.2
7	1	2.6
8	3	7.9
9	5	13.2
10	6	15.8
11	0	0
12	0	0
13	1	2.6
14	0	0
15	2	5.3
16	0	0

Table 4 shows the number and percentage of schools that had, did not have, or counsellors were not sure they had, the literature-recommended comprehensive school-based adolescent suicide prevention components. It is evident, upon examining this table, that there is considerable variability regarding which components are more common in the schools. Data indicate schools having (see Table 4):

- The following three components were individually present in over 70% of the schools: (1) "Group of school professionals who function as a team in relation to student's mental health issues (73.7%)", (2) "Mental health counselling to at-risk students (89.5%)", and (3) "Suicide reference materials for school counsellors (71.1%)."

- The most commonly implemented component (present in almost 90% of the schools) was "Mental health counselling to at-risk students".

- Each of the following four individual components were present in 50% or more of the schools. These components were: (1) "outside mental health professional on site as consultants to participate in suicide prevention (60.5%)," (2) "Prevention materials for distribution to students (65.8%)," (3) "Peer prevention classroom discussions (52.6%)," and (4) "Suicide prevention and intervention training for school counsellors (50.0%)."

- Between 30% and 40% of the schools implemented each of the following individual components: "Faculty training in the detection of warning signs (36.8%)", "Prevention materials for distribution to parents (34.2%)", and "Psychological screening programs to identify at-risk students (39.5%)."

- The following six components were individually present less than 20% of the time: (1) "Written formal suicide policy/program statement (18.4%)", (2) "Written procedures to address at-risk students (15.8%)", (3) "Staff in-service training and orientation to the program (5.3%)", (4) "Postvention component to be used in the event of an actual suicide (15.8%)", (5) "Written statement that describes specific criteria for counsellors to assess the lethality of a potential suicide (7.9%)", and (6) "Written statement that describes how the program is to be evaluated (5.3%)".

Table 4

Summary of the 16 Components in Place in the Schools

Suicide Prevention Component Present

Components in Comprehensive Suicide Programs	Yes		No		Do Not Know		Does not apply (School has no policy)	
	n	%	n	5	n	%	n	%
1. Written formal suicide policy statement	7	18.4	27	71.1	4	10.5		
2. Written procedures to address at-risk students in policy	6	15.8	1	2.6	4	10.5	27	71.1
3. Staff in-service training and orientation to the program	2	5.3	5	13.2	4	10.5	27	71.1
4. Mental health professional on site	23	60.5	15	39.5	0	0		
5. Mental health team	28	73.7	10	26.3	0	0		
6. Prevention materials for distribution to parents	13	34.2	23	60.5	2	5.3		
7. Prevention materials for distribution to students	25	65.8	13	34.2	0	0		
8. Psychological screening programs to identify at-risk students.	15	39.5	23	60.5	0	0		

Table 4 continued

Summary of the 16 Components in Place in the Schools

Suicide Prevention Component Present

Components in Comprehensive Suicide Programs	Yes		No		Do Not Know		Does not apply (School has no policy)	
	n	%	n	5	n	%	n	%
9. Prevention classroom discussion	20	52.6	17	44.7	1	2.6		
10. Mental health counselling for at-risk students	34	89.5	3	7.9	1	2.6		
11. Suicide reference materials for school counsellors	27	71.1	9	23.7	2	5.3		
12. Suicide prevention and intervention training for school counsellors	19	50.0	11	28.9	8	21.1		
13. Faculty training for detection of suicide warning signs	14	36.8	17	44.7	7	18.4		
14. Postvention component in policy	6	15.8	1	2.6	4	10.5	27	71.1
15. Written statement that contains criteria for counsellors to assess lethality	3	7.9	2	5.3	6	15.8	27	71.1
16. Written policy describing how the program is to be evaluated	2	5.3	3	7.9	6	15.8	27	71.1

Research Question 3: If, or when the subject of suicide is addressed during class, what

areas are covered?

Results show that more than half of the schools surveyed do indeed discuss suicide in

the classroom (n = 26, 68.4%). Those schools which discussed suicide all reported

covering the same areas in class. Topics included the following: facts/myths about

suicide, warning signs of suicide, resources about where to get help, and

problem-solving skills. Twelve schools (31.6%) did not discuss suicide in the classroom

as reported by the school counsellor.

Research Question 4: On the basis of their self reports, do school counsellors feel

prepared to curb suicides in their schools? If so, what contributes

to this feeling of being prepared? If they do not feel prepared,

what elements do they think are missing?

Data for this question revealed that many (68.4%) school counsellors felt prepared to

deal with suicide, some (15.8%) indicated that they did not feel prepared, while others

(13.2%) indicated both yes and no to feeling prepared. One individual did not answer

this question. Twenty-five participants provided written answers to this question. A

question content analysis of the responses suggested that those counsellors who felt

prepared to deal with suicide had attended workshops and presentations such as those

offered by the Support Network. This suggests that workshops can have a beneficial

effect on the counsellors feelings of confidence in dealing with issues related to suicide.

Additionally, counsellors who felt prepared indicated they had established community

networks, and were able to refer students to external agencies. This situation indicates

they are not alone (and therefore not totally responsible) in dealing with suicide. On the other hand, counsellors who did not feel prepared reported they had not received training in suicide and indicated their belief that a workshop would be beneficial. One counsellor reported having numerous personal resources, but did not feel prepared to deal with suicide because the school did not have a formal program or team in place. A number of counsellors indicated yes and no to this question, suggesting they had reservations in their ability to deal with the issue. They indicated that a lack of policy, many other duties, and no experience working with a suicidal student as contributing factors to this feeling. Sample responses include:

YES responses:

- "I have suicide intervention/prevention training, and training in critical incident stress management and I am developing good relationships with external agencies."

- "I have taken several Suicide Awareness/intervention programs. Several other staff have attended suicide awareness workshops. There is a crisis team within the school that would respond to an emergency like this."

- "My training over the years has included several "significant" training periods which included both theoretical and practical issues related to suicide."

NO responses:

- "Although I have a great number of personal resources around the issue of suicide, I feel unprepared because our school doesn't have any comprehensive policy/plan, nor does it have a team. One individual in semi isolation is unprepared in my opinion."

- "I do not have the proper skills as yet to deal with the problem. It would be beneficial to have a workshop for teachers/counsellors to deal with this subject. I do know however that our system has district people for us to call on should the need arise for students to deal with the death or suicide of a classmate. Unfortunately there is very little done for prevention at the junior high level."

- "I have had some training in my present counselling program however it has not been in depth and I feel this is an area where I require additional training."

Yes and NO responses:

- "The lack of a policy is a problem as well as access to counsellor in-service regarding the issue. As a staff, however, we work well together to address student needs early on and use our community resources. "

- "I have taken workshops and I have experience as a counsellor who has dealt with students talking about suicide, so I am somewhat prepared. On the other hand because of my many duties and the infrequency of hearing of students contemplating suicide that when it happens there is a real jolt to my system. I would like to take a workshop every year or every 2nd year but there are too many other issues or priorities I have to deal with, (wow what has a higher priority than suicide)."

- "I have no actual experience with a student who has committed suicide- and it is my worst nightmare that I might miss key signs in a student. So far we have been extremely fortunate- and have referred several students for outside counselling."

Research Question 5: Based upon counsellor self reports, what could be changed or

added to improve the way suicide is dealt with in their own

school?

Only 11 participants provided written responses to this question. Since less than half

of the total participants responded, it cannot be considered to be representative of the

schools sampled. It is interesting, and disappointing that so few participants responded to

this question. A question content analysis of those that did respond however, found the

following items recommended in their schools:

(1) Need for a formal suicide prevention program. Sample responses include:

- "Get a program"

- "Perhaps reactivate the formalization of the program."

- "We need to have a better approach to dealing with the problem of suicide. We could

   start by: having classroom presentations, staff in-service on warning signs, and

   broadening our team by including our liaison police officer."

- "Include prevention component."

- "This questionnaire reminds me that we should make sure this topic is included in

   our new Crisis Plan currently being reviewed."

(2) Training for all staff, not just counsellors. Sample responses include:

- "All staff need in-servicing in this area, not just counsellors and health teachers."

- "It would be wonderful if all of our teachers could take the course at the Support

   Network.";

(3) Better access to information about suicide. Sample response:

- "My own access to information as a beginning counsellor. I don't know what I don't know."; and

(4) More time available to be spent on suicide counselling. Sample response:

- "More counselling time. We no longer have a district consultant for counselling. We had one, a very efficient one. The position was cut and he is now working for another school board. As a result of our districts decision to remove our support, I have removed myself from the districts, crisis intervention team."

These responses indicate that suicide prevention efforts are not receiving the attention they should in many Edmonton and area schools. There seems to be enthusiasm and a genuine interest in this area but the responding counsellors seem to lack guidance and a driving force to make positive things happen.

Research Question 6: Based upon counsellor self reports what is/are the goals of the

current suicide prevention program?

Eleven participants responded to this question. A question content analysis of these responses revealed that the goals of suicide prevention are generally that of a Crisis Prevention Model. There was no discussion of promoting general mental health of students or increasing protective factors. Sample responses include:

- "To have no completed suicides."

- "Awareness, identification, and prevention."

- "Suicide signs and recognition."

- "Our goal is to communicate with the students how the program works. The importance of communicating to an adult. Self care and care of friends involved. To

take all depressing thoughts seriously. The counsellor follows the program taught from the Support Network.",

- "Maintain awareness of the problem. Keep kids healthy and alive. Provide information."

Goals such as "to have no completed suicides" or "to keep kids healthy and alive" are simply motherhood statements and give no indication of how these ideals might be obtained. One cannot determine if a program is in place with specific sub goals to make these overall goals happen or if these goals are based simply on hope and faith that things will be okay. In addition, the implication of these responses is that knowledge equals prevention and this is not always the case. One respondent provided the following reason to explain why there is no prevention program in his/her school: "No discussion, preventative programs, school awareness seminars/workshops exist. The teachers and parents in our community believe that in our middle class neighbourhood this doesn't happen and if we talk about suicide, it will put ideas into the kids' heads." This response is troubling because beliefs such as these sustain the myths about suicide and act as barriers to developing prevention programs in the first place.

Comparison with Malley, Kush, and Bogo (1994) study in the United States:

A comparison was made between this research and 11 of the components of the Malley et al. (1994) study. Five of the items were not included because differences in wording and response choices could have led to fallacious conclusions. Figure 1 contains a graphical comparison of the two studies. Overall the results of this study appear to be fairly similar with those of Malley et al (Refer to Figure 1). Both studies found the same two components most commonly implemented in the schools. These

components were the presence of mental health counselling available to at-risk students, and the existence of a group of school professionals functioning as a team to deal with student mental health issues. The major inconsistent finding was that half of the schools in the Malley et al. (1994) study had written formal suicide prevention policies, while only a minority of schools in this study did. In addition, Malley et al. (1994) found that only 56% of counsellors reported the availability of suicide reference materials, while 71.1% of the counsellors in the current study reported this material as being available. Also, Malley et al. (1994) reported that 50% of schools distributed prevention materials to students, while the current study reported 65.8% did, and finally Malley et al. (1994) found that 19% of schools offered psychological screening programs while the current study found 39.5% did. While there were some differences between these two studies, on the whole the results were fairly similar. It is interesting to see that the schools in this study were not radically different from those in the American study with regards to their suicide prevention efforts.

Figure 1

Comparison of Current Study to Malley, Kush, and Bogo (1994)
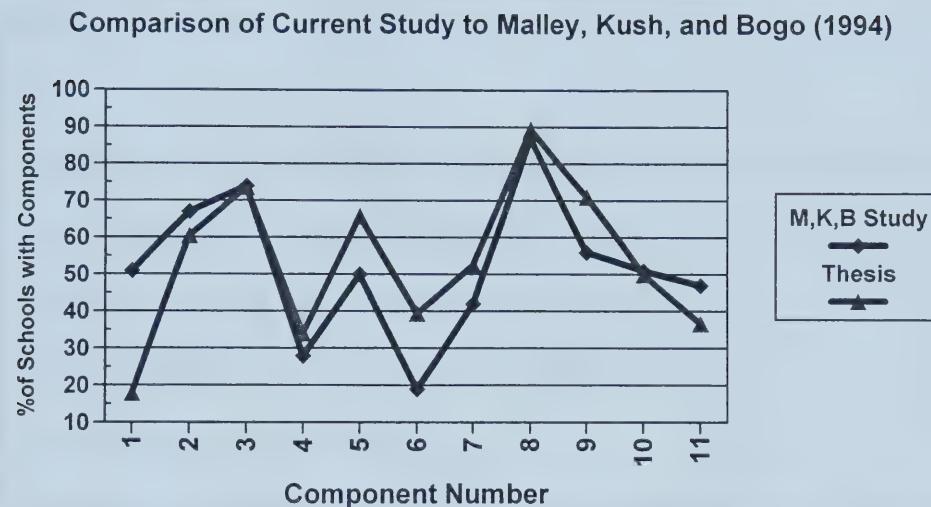
Figure 1. The above figure displays a comparison between the current study the Malley et al (1994) study.

Component Numbers represent:

1 = Formal written policy/program;
2 = mental health professional on site;
3 = mental health team;
4 = prevention materials distributed to parents;
5 = prevention materials distributed to students;
6 = psychological screening programs;
7 = classroom discussions about peer prevention;
8 = mental health counselling for at-risk students;
9 = suicide reference materials available;
10 = suicide prevention/intervention training for school counsellors;
11 = faculty training in detection of suicide warning signs.

At the end of the questionnaire space was provided in which the counsellors could make additional comments. Fourteen respondents provided written comments. Overall, the written statements contained several common themes. These included:

1) the need for a prevention policy/program at many of the schools. Sample responses include:

- "As we are all aware, staff, administration, and the priorities/beliefs they practice can change significantly in a relatively short period of time. For that reason, the development and promotion of a policy would be of real value."

- "A policy should be in place. It should be system wide"

- "we need a program in our schools"

- "We need a prevention program, get to accept that discussions doesn't put ideas into kids head, it helps them name and get a handle on their issues."

2) there is a need for access to more up-to-date information. Sample responses include:

- "Updated resource material would be helpful."

- "One issue of suicide that is most common at our school is homosexuality. Due to the way the catholic school/church regard homosexuality it can be very damaging for these teens. I wish I could find more research on this type of suicidal thought."

3) more time is needed to concentrate on counselling and there are not enough counsellors for ratio of students. Sample responses include:

- "For the past few years our student enrolment has been hovering around 1700 and we have 2 full time counsellors. We have lost a counselling consultant position at central office and have been informally meeting as a group of high school counsellors approximately once a month dealing with various professional topics. It is called

survival. The high schools simply cannot function without counsellors but many elementary and junior high schools are with the principal attempting in addition to their other daunting responsibilities to fill the void. I am saddened and sometimes stressed by the situation but am optimistic that with our budget surplus and persistence, counselling services will be augmented."

- "The world we live in demands less counselling time for schools (often administrators take counselling time) and more demands particularly on achievement scores, post-secondary scholarships etc. Will this change? I don't think so in the near future. I have been at our school for 18 years and I am aware of 3 suicides (there may have been more). I have talked to 2 of them. Could I have prevented their death, I don't know. I just know I am very busy and sometimes students don't receive the time they need to share their problems from the counsellors."

- "Cutbacks in education have set counselling back 10 or 15 years. Most elementary schools do not have counsellors because in school based budgeting the principal can choose to hire another teacher and forgo the counsellor. The kids are falling through the cracks-special needs programs are cut. Counsellors have great difficulty keeping up with the daily workload. Groups like the support network have helped a great deal."

- "Resources continue to be woefully inadequate for counselling services to adolescents in our division. We are staffed at 1.0 FTE per 1000 students for counselling services."

The implication of the above statements is that counsellors are over-worked and responsible for more duties than just counselling. It appears that counselling in the

schools may not be receiving the priority it deserves. Furthermore, it also implies the topic of suicide may not be a priority in many of the schools. The following statements support this view: "Our school experienced a student suicide at the beginning of this year. Parents mobilized and initiated the Yellow Ribbon Program. However, it doesn't seem to have had a spin-off into our school. One individual has little effect." "The topic of suicide does not play a huge role in our school and I'm sure in many other schools. Teachers and counsellors are spread pretty thin. Teachers cover the basics. Counsellors are more for *stamping out fires* than for preventing them. Too many areas to cover with to few resources." The implication of this last statement is that prevention does not play a significant role in some of the schools, and that issues are dealt with only during a crisis. This is troubling because it is not a proactive approach, instead it is reactive.

Overall throughout all the written responses the same themes emerged , suggesting that many of the school counsellors answering this survey shared many concerns and had similar ideas. The common themes were the importance and need of training in adolescent suicide, the need for a formal prevention program, and counselling does not seem to receive the attention it deserves in the school system. Overall the statements suggest a general feeling of wanting to help the students, however there are barriers in place that are blocking suicide prevention and counselling from becoming prominent.

CHAPTER V

DISCUSSION

Summary of Research Findings:

   This study provides a current assessment of the "state of reality" regarding suicide

prevention practices in a sample of Edmonton and district area schools. This study has

assessed programs on the basis of a comparison between the components of a given

schools program and the literature-recommended components considered essential for an

effective program. For the most part, these schools are addressing the problem of

adolescent suicide, but as a group there is considerable variation in the content and

structure of these efforts. In addition, although individual schools in this study may have

comprehensive suicide prevention programs, in general school-based adolescent suicide

prevention programs or efforts are not comprehensive when compared to the literature

recommended components. For instance, this study found that no school in the survey

had all the recommended components, and 55.3% of the schools have less than half of

the recommended components in place (less than 8 out of 16 components). On the

positive side however, all schools had some of the components, and 60.5% of the

schools had at least 6. These statistics indicate that there is quite a range in the

approaches taken by the schools within the sample, and there seems to be no standard

response to suicide prevention. It was also found that even though an individual school

might have a suicide prevention program, this effort may not be considered

comprehensive when compared to the literature recommended program. It does not

mean the program cannot be effective, but that it does not conform to the particular

literature standard selected for this research. The researcher believes however, that the

literature-based approach is a reasonable one, and it does embody most of the up-to-date research on adolescent suicide. From this perspective, it is strongly recommended that the schools use this research to review, and update their own programs. It could also be used by individual schools as a basis to assess their own "state of reality" regarding their suicide prevention program. This study could provide an impetus for such an evaluation, revision, and update of school programs.

Even though many researchers indicate that formulation of a policy and procedures is a crucial first step in establishing a suicide prevention program, this research has found that only 7 (18.4%) of the 38 schools had a formal written suicide prevention program/policy in place. A formal policy is important because it can provide organization, co-ordination, and support for the program, as well as an opportunity for input, revision, and refinement. It also provides a mechanism by which school personnel can clarify their roles and responsibilities, and the procedures needed for suicide prevention, intervention, and postvention.

Well-formulated policies take time to develop and require input from various levels of school staff. An involved staff helps assure their personal commitment. Of the schools with written policies in this survey, some crucial elements are missing within the policy. Specifically, there appears to be some room for improvement in the areas of developing evaluation procedures, providing training and orientation to the program, and written criteria for use in assessing lethality. Without these components, the potential benefits of the programs may not be fully realized and their content can quickly become out of date and irrelevant. However, it was encouraging to find that the majority of

schools with policies had written procedures to address at-risk students during crises and postvention.

The most common components being implemented in the schools were the following: (1) a group of school professionals who function as a team at the school in relation to student's mental health issues (73.7%), (2) some form of mental health counselling provided to at-risk students (89.5%), and (3) suicide reference materials available for school counsellors (71.1%)." These findings are encouraging. However, a number of components were found to be lacking in the schools. These were: (1) formal suicide prevention policy/program (18.4%), (2) psychological screening programs (39.5%), (3) educational prevention materials for distribution to parents (34.2%), (4) and school faculty training in the detection of suicide warning signs (36.8%). These are areas where there is room for improvement.

The data regarding "counsellor feelings of personal preparedness" appear to be encouraging and positive, because many of the participants (68.4%) reported feeling prepared to deal with suicide. A major factor contributing to this feeling of confidence, appeared to be their attendance at workshops and in-services (such as that provided by the Support Network) dealing with adolescent suicide prevention/intervention. There seemed to be a general consensus among the counsellors that these workshops are important, and school administrators should ensure that their counselling staff have the time and resources to take advantage of these workshops. Additionally, those who design school counsellor training programs might consider implementing suicide prevention training as part of their curriculum. The results of counsellor feelings of preparedness are surprising when compared to the American findings of King (2000) and

Kush (1991). Both of those studies found that more than half of the counsellors felt unprepared to curb suicides, while in this study the opposite was found.

The majority of schools (68.4%) reported that suicide was discussed in the classroom, and that these discussions covered topics such as myths/facts about suicide, resources available for assistance, warning signs, and problem-solving skills. Although their focus on problem-solving skills is considered very positive, evidence is inconclusive about the effectiveness of these educational programs in the prevention of adolescent suicide. The assumption behind discussing the topic is that knowledge can lead to prevention. As with many issues this is not always the case. In addition, the goals of most suicide prevention programs appear to be that of Crisis Prevention Model. There do not seem to be any goals related to promoting an adolescent's general mental health. In addition the goals do not appear to be specific. For instance two respondents cited "to have no completed suicides" and "to keep kids healthy and alive" goals. Goals such as these are overall ideal goals but there was no mention of any sub goals in place to attain these ideals. Administrators are encouraged to examine the option of establishing programs that have goals that concentrate on the general mental health of the student. Such programs would educate students in the development of skills such as coping strategies, decision making, stress management, communication, and self-esteem enhancement which are generally accepted as protective against suicide.

It was disappointing that more than half of the responding counsellors did not provide suggestions for improving or changing the methods for dealing with suicide in their schools. This could imply that most counsellors are satisfied with the approach their school is currently taking, or that they did not know what to recommend. Those who did

respond however, provided some important points that should be considered by school administrators. Responses revealed: (1) the need for a formal suicide prevention program, (2) training for all staff, not just counsellors; (3) better access to up-to-date information about suicide, (4) providing more time to spend on counselling, and (5) increasing the counsellor to student ratio. The implication of this last statement is that some counsellors may feel overworked and responsible for duties other than counselling. At a time when statistics indicate Alberta youth are seriously troubled by thoughts of suicide, it was disconcerting to find that counselling may not be given the priority it deserves in some of the schools. Many counsellors appear overburdened which could be detrimental to some students in need. This information is interesting considering that 89.5% of counsellors reported that their school provided some form of mental health counselling to students considered at risk.

Overall throughout the written statements provided by the counsellors the same themes kept emerging. There seems to be a consensus among the counsellors in regards to the need for prevention programs to be in implemented, the importance of training in adolescent suicide, and more time and staff are needed for counselling services. The fact that most schools do not have a formal program in place is interesting, given that many school counsellors reported the need for one. Possible reasons for this may include; (1) suicide is not considered a pressing issue by many in the school, (2) there is insufficient funding available, (3) there is no time to implement one, and (4) personnel are not available to develop and participate in it. Finally, there appears to be enthusiasm, a desire to help, and a genuine interest in this area among the counsellors.

Limitations of the Current Study:

There are a number of limitations and modifications that could be made to improve this study. Following is a list of the most obvious ones.

1. This study was based on a relatively small sample size (n = 38). This fact makes the generalizability of the results extremely limited. It makes it difficult to confidently draw conclusions that would apply outside the area included in this study. If the survey was repeated, the number of prospective schools making up the sample would be increased to insure that a greater number of responses were obtained. In addition, surveys would be sent to all counsellors, and not just those who were contacted during the initial and follow-up phone calls.

2. The fact that this study contains descriptive research may not be satisfying to some researchers. Although descriptive research is limited in its depth of investigation, this study did provide an estimate of the state of reality in the specific school districts that were sampled. It was successful in obtaining a flavour of the state of suicide prevention programming in Edmonton and area schools, and may be used as a starting point for more in-depth studies that may be planned in the future.

3. It was unfortunate that the school districts represented by the student school counsellors could not be determined. Such information is usually considered necessary to describe the population demographics of a survey sample.

4. Because of the nature of the method chosen, follow-up questions which could have provided valuable information were not permitted. It would have been better to conduct interviews on the basis of the written responses to gain a more complete

picture of the issues. Such follow-up questions would be recommended in future surveys of this type.

5. In a future survey, the wording of many of the questions would be modified. For example, questions that asked whether or not a school policy had written components to deal with various aspects of suicide, had to assume a formal program existed. Some of the schools without a formal policy/program could still have had an equivalent component in place, however the wording of the question made it impossible to determine if this was, or was not, the case.

Implications for Practice:

School administrators and staff must be kept up-to-date regarding the serious issue that suicide poses to youth in Alberta. Statistics show that the provinces' adolescents are seriously troubled by thoughts of suicide. These statistics should be made available to school personnel to help stimulate the development of programs and funding to appropriately deal with the issue. There must be avenues in place for youth to follow when they need help, and schools seem to be a logical place to begin this process.

The component section of this research has the following implications for practice:

1. School officials should review the components of the comprehensive school-based program described in this report, and see how their school measures up with the recommended components, and how it compares to other schools in the greater Edmonton area. Armed with this information, they may wish to revise or modify their own programs to bring them in line with current research.

2. For those schools that do not have a formal written policy on suicide prevention, it is *strongly* recommended that school officials, with the assistance of outside mental

health professionals, develop policy statements and objectives to guide their actions. This will ensure that there is general agreement on how the issue should be approached, that everyone is aware of their roles and responsibilities, and they are prepared to act effectively if a problem should develop. Procedures and policies are great tools to provide organization and structure to any prevention, intervention, and postvention effort, regardless of how many components a school may decide to implement.

3. Those schools that have a formal written policy/program should develop an evaluation component to ensure that their program is up-to-date, well staffed with qualified people, and attaining the schools desired goals.

The written responses of the counsellors have the following implications for practice:

1. Because workshops and in-services were identified as being helpful in preparing counsellors to deal with suicide, school districts should consider providing a mandatory workshop each year to keep their counsellor/s current with the latest research in the field. Additionally, school counsellor training institutions may want to consider implementing suicide prevention, intervention, and postvention training as part of the curriculum because it is an issue that many counsellors working in schools will inevitably have to face.

2. Suicide prevention programs should be broadened to include a curriculum that promotes the students general mental health. This may effectively increase the factors which are protective against suicide. However, it would be in addition to the crisis prevention model which is important as well. Moreover, programs should develop specific goals to guide their actions.

3. Counsellors have indicated in their written responses the need for prevention

    programs to be in place. School administrators should consider this option.

    For those interested in implementing a comprehensive suicide prevention program in

their school, the author refers them to a useful resource entitled *"Suicide Prevention in*

Canadian Schools: A resource." This book was developed by the Canadian

Association for Suicide Prevention, edited by Wenckstern, Leenaars, and Tierney (1995).

It includes information on the development of comprehensive school suicide prevention

programs, a sample comprehensive suicide prevention program used by one school,

prevention and intervention issues among native youth in Canada, suggestions on how to

work with suicidal youth, and ideas for dealing with the aftermath of a youth suicide.

This manual has a Canadian focus, and is one of few resources that focus on the

Canadian scene. It also contains many useful references. This book is available from the

Suicide Information and Education Center in Calgary.

Finally, schools might consider implementing the Yellow Ribbon Program. The

purpose of this program is to reduce youth suicide. It was developed by parents whose

son committed suicide and is implemented in schools internationally. Youth are given

cards in the schools to use as a tool to help them reach out in time of crisis. Information

on these cards is provided to adults who might receive them such as teachers,

counsellors, and parents, so they can respond effectively. The cards also contain the

numbers of local help lines to contact in time of need. By having a card teens do not

have to worry about how to ask for help, or what they will say. All they have to do is

hand the card to someone for example a teacher or counsellor, and the person will know

that the young person needs help, and direct them to it. Further information is available

on the following web site: **http://www.yellowribbon.org**

Directions for Future research:

This study can be useful as a starting point for future research in the following areas.

1. It would be interesting to conduct this study province-wide and possibly nation-wide

    to obtain a more complete picture of how suicide is dealt with in Canadian schools.

    This information could be used to develop a standardized and co-ordinated approach

    for dealing with adolescent suicide in Canada. It would also allow school

    administrators to see how their schools program compares to other schools in

    Canada.

2. Because counsellors in this study promoted the benefits of attending workshops, it

    would be interesting to explore this training, and highlight those areas identified as

    being most beneficial by counsellors. For example, did the training and experience of

    the presenters make a difference, what was the counsellor level of knowledge of

    suicide prior to the workshop, were specific topics more valuable than others, etc.

    This research could then be used to further improve workshops and in-service

    sessions.

3. More specific detailed information about the programs should be sought. For

    example, in the intervention or postvention components, what procedures were

    actually used?

4. Because counsellors expressed a need for formal prevention programs at their

    schools, it could prove beneficial to explore some of the reasons why most schools

    do not have a formal policy/program in place; what are some of the roadblocks or

barriers to its establishment, etc. In this regard, not only the opinions of counsellors should be sought, but also the perspectives of principles, teachers, and other selected staff members.

5. A survey of suicide information on the web should be carried out. This powerful source of information is available to an increasingly large number of youth, and can prove to be both beneficial and disastrous to troubled teens. The author carried out a general search of the Internet and was horrified to find web pages showing how to commit suicide successfully. For example, there are web sites describing how many Tylenol to take to kill oneself, the proper way to slit one's wrists, or the proper amount of a poisonous substance to drink. Knowledge that this information exists, and its extent should be communicated to schools and parents so they can take action to prevent its exposure to at-risk individuals.

6. A study should be conducted to see if there is a relationship between years experience as a school counsellor, and their feeling of being prepared to deal with suicide.

7. Finally, it would be informative to determine if there is any correlation between the number of literature recommended components in place and the existence of a formal written policy at the schools.

Conclusion

In conclusion, school based suicide prevention programs are continually evolving, and developers should strive to keep up-to-date with the most recent empirical research in the area. As knowledge continues to grow, programs should be updated, modified, and revised in accordance with the best research, and the needs identified by on-site

evaluation data. This kind of proactive approach is essential if suicide prevention programs are to succeed.

Final Thoughts

This research project has persuaded the author to alter her position in the area of suicide prevention in schools. The author believes it will be more beneficial to deal with suicide prevention within the context of a broader general mental health program which promotes the development of factors protective against suicide, than actually highlighting suicide as a special subject for discussion in classrooms. Because of the extensive list of risk factors, there seems to be a common pathway to many mental health problems, and focusing broadly on general mental health and well being (with the comprehensive suicide prevention program as part of this broader framework) a wide variety of problems including suicide may be able to be prevented.

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Appendix A

16 Components of Comprehensive Suicide Prevention Programs

Malley, Kush, and Bogo (1994) conducted a complete literature review of the most

commonly referred to components in comprehensive suicide prevention programs. They

came up with the following 16 criteria:

1. Formal, written suicide policy statements are present.

2. Written procedures to address at-risk youth are available within this policy.

3. Staff in-service training and orientation to the program are provided.

4. A mental health professional is present on site as a consultant to address suicide

   prevention.

5. A mental health team is available.

6. Suicide prevention materials are distributed to parents.

7. Suicide prevention materials are distributed to students.

8. Psychological screening programs to identify at risk youth are available.

9. Suicide prevention classroom discussions about peer prevention are carried out.

10. Mental health counselling for at risk students is available.

11. Suicide reference materials are available to counselors.

12. Suicide prevention and intervention training is available for counsellors.

13. The faculty receives training in the detection of suicide warning signs.

14. A postvention component is available.

15. There are written statements that contain criteria for counsellors to assess the

    lethality of a potential suicide candidate within the policy.

16. There is a written policy describing how school based adolescent suicide prevention and intervention programs are evaluated.

Appendix B
Informed Consent Form

A Descriptive Study of Adolescent School-Based Suicide Prevention Programs

Please read the following section carefully.

1. I understand that the purpose of this study is to survey and describe the current practices for adolescent school-based suicide prevention programs in the Edmonton region. In addition, the researcher will inquire about my perspectives on suicide prevention. Finally, the researcher will inquire about some background information about suicide prevention in my school. My participation will involve answering questionnaire items pertaining to this topic. This study will be conducted as a Master's thesis project by Andrea Forgeron, under the supervision of Dr. Robin Everall, Asst. Professor, from the Department of Educational Psychology at the University of Alberta.

2. I understand that my responses will be *strictly confidential*. I will remain anonymous as my name will not appear on the questionnaire. Instead, data will be identified by code number, not by name, and be reported in group format only. Only the primary researchers will have access to the questionnaires (i.e. Andrea Forgeron and Dr. Robin Everall).

3. I understand that the information I provide will be analysed for a Master's thesis project. The results of this study may be presented at conferences, workshops, inservices, and/or published in professional journals.

4. I understand that my participation in this research is *voluntary*. I am aware that I am free to refuse to participate in this study or to terminate my participation at any time.

5. I understand that for the results of the survey to be meaningful, it is important that I try to answer all questions as accurately as possible. However, if I do not want to answer a specific item, I do not have to. This questionnaire should take approximately 15-20 minutes to complete.

6. I certify that I have read the preceding and that I understand its contents. My signature below means that I have fully agreed to participate in this descriptive study.

_____   _____

Participant Name (Print)   Date

_____

Participant Signature

For further information or any questions concerning the study, please contact:
Andrea Forgeron (Master's student) 492-3746
Robin Everall Ph.D. (Supervisor) e-mail: robin.everall@ualberta.ca or 492-1163
Department of Educational Psychology (Counselling Psychology)
University of Alberta, Edmonton, Alberta, Canada

Appendix B
Information Form

Dear Counsellor,

My name is Andrea Forgeron. Through the University of Alberta, Department of Educational Psychology, I am conducting a survey study for my master's thesis and invite your participation.

Adolescent suicide is a major concern to all society, and the procedures being used to address this problem are important to us all. This study is concerned with describing the current practices for adolescent school-based suicide prevention programs. Because you are close to the problem, some questions requesting your perspective on the issue are included, as well as some background questions about your school. You do not have to answer any questions that make you feel uncomfortable .

Enclosed you will find a Consent Form, the Survey, and a stamped envelope. Please read thoroughly, sign the consent form and complete the survey. Please return both documents in the envelope by March 10 th. 2001. Your co-operation will be greatly appreciated. By completing this survey you will have contributed to the body of knowledge in this field. If you are interested in the results of this study, or have any further questions, please contact either one of the researchers below. A research report will be made available upon the completion of the study. Please keep this sheet for your information.

Thank you very much for your time,

Sincerely,

Andrea Forgeron (Master's student) 492-3746
Robin Everall Ph.D. (Supervisor) e-mail: robin.everall@ualberta.ca or 492-1163
Department of Educational Psychology (Counselling Psychology)
University of Alberta, Edmonton, Alberta, Canada

Appendix B
Part 1: Demographic Information

1. What school district are you from?

    A. __ Elk Island Public Schools
    B. __ Edmonton Catholic Schools
    C. __ St. Albert Protestant Schools
    D. __ Other

2. ___ Number of years practising as a school counsellor:

3. __ Male
   __ Female

4. Check the highest degree you have obtained

    A. ___ B.Ed
    B. ___ B.Ed After Degree
    C. ___ M.Ed
    D. ___ Ph.D
    E. ___ EdD
    F. Other (specify) _____

Part II Program Survey. Please complete to the best of your knowledge. Do not seek information out of any documents.

1. Does the school where you are currently working have a formal written adolescent suicide prevention policy/program?

___ Yes
___ No
___ Do not know

2. Does the school suicide prevention policy or program contain written procedures for school personnel to address student suicidal behavior or crises?

___ Yes
___ No
___ Do not know
___ Does not apply (school has no policy)

3. Has your school conducted in-service training in order to orient school personnel to the school's suicide prevention program/policy?

___ Yes
___ No
___ Do not know
___ Does not apply (school has no policy)

4. Does your school incorporate mental health professionals on-site at school as consultants/service providers (facilitating groups, individual counselling, classroom speakers) to help address the issue of adolescent suicide prevention?

___ Yes
___ No
___ Do not know

5. Does your school have a group of school professionals (a "team") who functions on-site at school on an ongoing basis that is concerned with students' mental health issues?

___ Yes
___ No
___ Do not know

6. Did your school provide any educational activities or materials regarding teen suicide prevention to the parents in your school district during the 1999-2000 school year?

__ Yes
__ No
__ Do not know

7. Has your school provided any educational activities or materials regarding teen suicide prevention to the parents in your school district during the 2000-2001 school year?

___ Yes
___ No
___ Do not know

8. Does your school distribute any suicide prevention materials (pamphlets, handouts, etc.) to students?

___ Yes
___ No
___ Do not know

9. Does your school utilize psychological screening programs with the student body for variables found to be associated with adolescents who are at high risk for suicidal behaviour?

___ Yes
___ No
___ Do not know

10. Does your school incorporate classroom discussions about peer prevention of adolescent suicide as a regular part of the counselling curriculum?

___ Yes
___ No
___ Do not know

11. Does your school offer mental health supportive counselling programs (either individual or group) for students who are considered to be at-risk for psychological or behavioural problems (i.e., students who have histories of depression, students experiencing a personal loss, students who present substance abuse concerns)?

___ Yes
___ No
___ Do not know

12. Does your school have available to you a comprehensive body of material regarding adolescent suicide for your immediate reference if necessary?

___ Yes
___ No
___ Do not know

13. Has your school district provided adolescent suicide prevention/intervention training specifically for the counselling staff?

___ Yes
___ No
___ Do not know

14. Has the faculty in the school where you work been trained in detection of adolescent suicide warning signs?

___ Yes
___ No
___ Do not know

15. Does your school's suicide policy include a postvention component in the event that a student at your school commits suicide?

___ Yes
___ No
___ Do not know
___ Does not apply (school has no policy)

16. Does your school's suicide prevention policy contain specific criteria for counsellors to assess the lethality of a potentially suicidal student during a crisis intervention?

___ Yes
___ No
___ Do not know
___ Does not apply (school has no policy)

17. Does your school's suicide prevention policy/program contain an evaluation component of the program's functions and outcomes?

___ Yes
___ No
___ Do not know
___ Does not apply (school has no policy)

18. If your school has a prevention program, what is/are the goals of the current program?
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

19. If your school discusses the topic of suicide in the classrooms, what topics are covered? (check all that apply)

___ Does not apply (do not discuss the topic in class)
___ Facts/Myths
___ Warning Signs
___ Resources on where to get help
___ Problem Solving Skills
Other:_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

20. Do you feel prepared to deal with the problem of suicide in your school?

___ Yes
___ No
Explain._____
_____
_____

_____
_____
_____
_____
_____
_____
_____
_____
_____
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_____
_____

21. Is there anything you would change about the way your school deals with the issue of
suicide? Please Specify.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Is there anything you would like to add or further comment on?

_____
_____
_____
_____
_____
_____
_____
_____